PROVISION OF EXTENDED CARE TO VETERANS IN FLORIDA BY THE DVA

HEARING

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

JUNE 16, 1990

Printed for the use of the Committee on Veterans' Affairs

Serial No. 101–51

U.S. GOVERNMENT PRINTING OFFICE
33-894 WASHINGTON : 1990

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

HT61-2.

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PROVISION OF EXTENDED CARE TO VETERANS IN FLORIDA BY THE DVA

Saturday, June 16, 1990

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:10 a.m., at the Conference Center of the Ocean Center, 101 North Atlantic Avenue, Daytona Beach, FL, Hon. Lane Evans (chairman of the subcommittee) presiding.

Present: Representatives Evans and James.

OPENING STATEMENT OF CHAIRMAN EVANS

Mr. EVANS. Good morning and welcome.

The Subcommittee on Oversight and Investigations is pleased to be here in Daytona Beach this morning. We are here today at the invitation of Congressman Craig James, an active and valued member of the House Committee on Veterans' Affairs. At his request, we have come here to examine the provision of extended care to Florida's veterans by the Department of Veterans Affairs.

America's veterans are aging. In 1980, there were three million veterans nationwide who were 65 years or older. At that time, senior veterans comprised about 10.5 percent of the total veteran population. Today, older veterans number between seven and eight million nationally, and they are now more than 25 percent of the total veteran population. According to the experts, this trend will continue. In the year 2020, older veterans are expected to account for 44 percent of the total veteran population nationwide.

Florida, not surprisingly, is a leader in the changing nature of our veteran population. Today in Florida, veterans who are 65 years or older already comprise one-third of the State's veteran population. By the year 2000, Florida's senior veterans will account for more than 45 percent of the total State veteran population. In the year 2020, almost one-half of the veterans in Florida will be 65 years of age or older.

We recognize that aging is not synonymous with infirmity. We also recognize health care needs of veterans change as they grow older. For example, older veterans use more ambulatory care services. Veterans 75 years and older use three times as much ambulatory care as veterans who are less than 55 years old. Nursing home use by veterans 85 and older is 20 times that of veterans who are

55 to 65, and veterans 65 and older may have twice the number of hospital stays per capita as veterans who are 45 to 64.

Today the subcommittee will examine a number of issues which are important to all veterans and especially to the growing population of older veterans. These issues include the present and future extended care needs of Florida veterans; current and planned VA extended care programs in Florida; the strategy and plans of the Department of Veterans Affairs to meet the extended care needs of Florida veterans; eligibility for VA provided extended care; and the resources needed to provide extended care to an aging veteran population.

In addition, we will review the Geriatric Research, Education and Clinical Center program of the Department of Veterans Affairs. We will explore the purpose and goals, the record, and the proposed future course of the GRECC program. Achievements in geriatric clinical care, education and research, and the dissemination of information derived from GRECC activities are among the issues which are expected to be examined.

Soon after becoming the first Secretary of Veterans Affairs, Ed Derwinski was asked how the VA would respond to the rapidly growing aging veteran population. He said, "I told our people to make sure they've dusted off all their plans and to be ready for it. We don't need to study it. We don't need to go back to the drawing board for new plans. They had better have some good ones ready to go. If they don't, they've been derelict in their duties."

Today we want to examine the VA's plans to meet the health care needs of an aging veteran population here in Florida, with special emphasis on extended care. Are those plans adequate, have they been "dusted off", and are they ready to go?

The subcommittee appreciates the attendance here today and the excellent cooperation and assistance we have received in preparing for this hearing. We especially want to thank and publicly acknowledge the contributions of Congressman James and his staff. The Ocean Center and its excellent staff also deserve special recognition for their contributions.

You may know that a gun and knife show is also being held here at the Ocean Center today, which accounts for the added security that you saw when you walked in the door.

It is a pleasure for me to now recognize Congressman Craig James for any comments he would like to make at this time.

There are many things which I could say about Craig James, but I will emphasize only two. First, his attendance in the subcommittee for the various hearings we have is outstanding. I'm afraid that if I'm ever late for a subcommittee hearing, I would find him presiding when I arrived.

Second, new Members of Congress are expected to be seen and not heard, but apparently no one explained that to Congressman James. He has been both seen and heard. As a result, during the relatively brief time that he has served in Congress, he has established himself as a vocal, persistent and effective advocate for all veterans of all eras. I look forward to his constructive and important contributions today, as always, and I welcome his comments.

Congressman James.

OPENING STATEMENT OF HON. CRAIG JAMES, A REPRESENTATIVE IN COMGRESS FROM THE STATE OF FLORIDA

Mr. JAMES. Welcome to Daytona Beach, Mr. Chairman.

I would like to thank you for those kind words, and I appreciate all the help and guidance you have provided me during my 18 months in Washington. I also want to commend you for your dedication and loyalty to the veterans of this Nation. I would also like to thank Mike Durishin and Pam Parker for all of their help in organizing this important hearing. Finally, I want to thank and welcome everyone who has come today to listen to this important hearing.

Mr. Chairman, the problems that all veterans face are numerous and varied. But today, we are here to examine a specific problem that is acute for many of the veterans around our Nation. We are here to examine the long-term care needs of our aging veteran population.

Congressman Evans, your figures and projections on the total number of veterans 65 years of age and older are right on target, and those figures should give us reason to pause and question what will happen to our aging veterans population.

Currently, the median age of the Florida veteran is 60 years of age. Approximately 1.5 million veterans currently live in Florida, with 48,000 veterans moving into the State each year.

By the year 2020, it is estimated that the Florida veteran population will reach 2.4 million and, of those, almost 50 percent will be over 65 years of age. Many of those veterans will need and demand health care services, and at the present time we simply are not prepared to provide them. Now is the time to review and implement a long-range plan to care for these veterans before the state of health care reaches crisis proportions.

The need for acute inpatient care, long-term hospital care, and nursing home care will be critical. We must work today to meet our veterans' long-term care needs of tomorrow. Despite the daunting task that faces us, I am confident that we can find the solutions to these pressing problems. We have a responsibility to those brave men and women who have defended our Nation, and we will keep that promise. I am looking forward to hearing the testimony and recommendations of our panelists, and I will continue to work with Chairman Evans, Members of Congress, and the veterans of Florida and the Nation to meet these critical health care needs.

Mr. EVANS. Thank you, Congressman.

Mr. JAMES. Before we go on, I would like to thank the Volusia County Sheriff's Department and the Capitol Hill Police for all the help in providing the security at this hearing, and also the staff of the Ocean Center for providing this beautiful facility. Thank you all so very much.

Mr. EVANS. Let me also thank them as well.

Before we call our first panel, I would like to remind everyone that today's hearing is a formal hearing of the House Veterans' Affairs Committee. Throughout this proceeding, the committee requests courtesy be demonstrated by all who are in attendance. In particular, courtesy is expected to be shown to all witnesses who are scheduled to testify today. Because this is a formal hearing, the

committee requests that all public expressions of support for or opposition to witnesses' testimony be withheld during the hearing. To facilitate this hearing, and to ensure all scheduled witnesses have ample time to present their views, the committee further requests all comments and questions from the audience be withheld during the course of the proceedings.

Before calling our first witness, the Chair notes four members of the Florida delegation—Senator Mack and Congressmen Bennett, Hutto and Lewis—were not able to be here today but have submitted a statement for the hearing record. We welcome their contributions to the hearing and their statements will be made a part of the record. We certainly appreciate their continuing support for our Nation's veterans.

[The statements of Hon. Connie Mack, Charles E. Bennett, Earl Hutto and Tom Lewis appear at pp. 37, 39 and 42.]

Mr. EVANS. Our first witness this morning is Maj. Gen. Earl G. Peck, Executive Director, Florida Department of Veterans Affairs. General Peck is retired from the United States Air Force following an outstanding career. His numerous service decorations include the Defense and Air Force Distinguished Service Medals, Legion of Merit with three oak leaf clusters, the Bronze Star, the Vietnam Service Medal with four campaign stars, and the Republic of Vietnam Cross of Gallantry with palm.

We welcome you, General. We have your entire statement for the record and you may proceed in any way you wish.

STATEMENT OF MAJ. GEN. EARL G. PECK, USAF (RET.), EXECUTIVE DIRECTOR, DEPARTMENT OF VETERANS AFFAIRS, STATE OF FLORIDA

General PECK. Thank you, Mr. Chairman, Congressman James. It is a pleasure for me to be here this morning on behalf of the Governor and the cabinet and all of the 1.54 million veterans in Florida.

As you noted, I have submitted written testimony. I won't repeat anything I have said in that written testimony. I would like to simply, in my few brief moments here this morning, encapsulate the problem for the State of Florida.

As you noted, Florida now has the fourth largest veteran population in the United States, growing in absolute numbers faster than any other State in the Union—not California, not Texas, not Alabama, not Georgia, not Illinois, but Florida.

At the same time, as you noted, we have the oldest median age population, the highest incidence of service-connected disability, the most severely disabled veteran population, and the highest concentration of World War II veterans in the Nation. We also have, incidentally, the largest gathering of female veterans in the United States.

All of these things would predict a high demand on the VA health care system. While that's true, at the same time we're near the bottom in access to VA health care in the United States. We have the least discretionary care of any State in the United States, the highest level of service-connected care of any State in the United States, the third fewest VA hospital beds per thousand vet-

erans of any State in the United States, and the least psychiatric care capability of any State in the United States.

All of this causes not only a problem for the veterans but it causes increased confrontations and stresses on the VA health care workers themselves who suffer, because they're the ones who tell the veterans we can't take care of you and, therefore, absorb some of the blame which belongs someplace else.

The roots of the problem are, as many of you know, in a chronic underfunding of the VA budget as a whole, not limited to but focused today on health care, but it also extends into the benefit administration. Another root of the problem is in Congress itself, the constraints on the VA's ability to reorganize. Each time the VA attempts to phase down a hospital in Walla Walla, WA or someplace else in order to redirect resources to Florida, there is an inhibition on that action, frequently by somebody in the Congress of the United States.

There are other institutional factors. As in any large institution, there may be some bureaucratic inertia. Perhaps some of those plans which Secretary Derwinski referred to as dusting off really need some refurbishing and modernization.

Among the solutions, rather apparent, I think, is adequate funding for the VA system as a whole. By that I mean a refocused system so that veterans in Florida enjoy the same level of health care as those in Massachusetts or Illinois or Wyoming or someplace else.

Again, I would urge you to ease constraints on the VA's ability to reorganize. Given the best of intentions, if in each instance they must go back to Congress in order to reallocate people or moneys or medicines to Florida, that tends to slow down or totally inhibit the process.

Again, I would urge continued progress in the programming and budgeting for increased facilities in Florida. I note with pleasure the fact that this year we did get a new VA medical center for Palm Beach, an associated nursing home, and a long-term psychiatric care unit in Gainesville, an increase in the spinal cord injury unit in Tampa. All these things are good, but we must continue progress in that direction.

At the same time, I would urge some attention immediately to alternative means of taking care of today's veterans. The average World War II veteran is now 69 years of age, and long-term facilities which may open in 1998 or the year 2002 will be academic. So I would urge this committee and the U.S. Department of Veterans Affairs to focus on some things which could be done immediately: increased resources for home health care, for example, perhaps the increased use of voucher and fee basis systems, all of these with guarantees that this will not in any way jeopardize the construction of needed facilities for Florida in the future. We must do this because this generation of veterans can't wait for the Taj Mahals of the future. We need to take care of them today. I urge you to do something to enable a better reallocation of resources in accordance with the migration of people.

Thank you very much, Mr. Chairman.

[The prepared statement of Earl G. Peck appears at p. 47.]

Mr. EVANS. Thank you, General. We appreciate your excellent testimony.

We also have an advance copy of Mr. Thompson's statement, who is, of course, Director of the Southeast Region of the VA. He is going to testify that only 16 percent of the veterans who require nursing home care will be served by the VA. Do you agree or disagree with this policy, and can you tell us which veterans you think should be entitled to VA nursing home care? Any other comments that you might have would be appreciated.

General PECK. The U.S. Department of Veterans Affairs projects a significant shortfall in nursing home beds for veterans alone in Florida by the year 2000. We could quibble about the numbers, but even by their conservative estimates, it will be at least 3,000 beds. In the VA's normal formulation, they would satisfy about 30 percent of those in their own facilities, perhaps 30 or 35 percent under contract, and the remainder in what is termed the Federal/State home partnership program.

Heretofore, the VA generally did not credit Florida with much ability to take care of its share of that problem. I would be happy to report to you as an aside that this year, over insuperable odds in Tallahassee, we convinced the legislature to allocate its share of moneys for a State skilled nursing home for veterans with participation to the tune of 65 percent by the Federal Government. We're relatively well assured in Washington that, given that commitment, we can rise pretty near the top of the list. So we think a reinvigorated State program along with the VA living up to its obligations, we can make a significant dent in what will be a problem for the State of Florida as a whole, apart from the veteran population. We can solve it in a prudent and economic way through the veteran population so as to relieve resources which would come from other places to take care of the remainder of the problem.

Mr. EVANS. I understand that the first Florida State veterans home and domiciliary care unit was recently dedicated at Lake City. We want to congratulate you for that. We think you've shown leadership in that regard. We do think Federal/State cooperation will benefit veterans.

General PECK. Yes, sir. We did dedicate the domiciliary home in Lake City on the 26th of May, and Congressman James was kind enough to send up a letter telling us what great guys we were and what a great job we had done. We appreciate that.

Mr. EVANS. Let me yield to him for any comments or questions he might have.

Mr. JAMES. Thank you so much for your statement enlightening us about all those issues that you and I have discussed many times, but you've put it in a very concise and understandable fashion and I want to thank you so much for that. It needs to be in the record in a concise way.

In Florida, how do we handle the problem of veterans that actually live in other States and spend three to 6 months here, though they are actually residents in some other places? Is there some kind of change or approach that we should recommend in order to account for those additional services that are demanded of this State that are not reflected by the census?

General PECK. I believe, Congressman James, we need a reformulation of the resource allocation system for the Department of Veterans Affairs, one which recognizes the dynamics of changing demographics and the fluidity of demographics. We net about 3,600 new veterans in Florida each month. That number is higher in the winter and lower in the summer. Some of them come and stay, and some of them go back to Illinois. But we need some formulation which allows the U.S. Department of Veterans Affairs to provide resources which takes care of that population, at least on the average. As it is now, people come down to Fort Myers from Massachusetts and say, while they're giving me medicines and taking care of me in Massachusetts, why aren't you bad guys in Florida doing it? We explain all the reasons why we can't, because we don't have the resources in Florida. The VA takes an enormous part of the blame which it doesn't deserve, because it simply can't keep up with that changing population.

So I think we need a new, dynamic formula for resource allocation in the U.S. Department of Veterans Affairs which will take care of that population shift and the varying levels of population in Florida.

Mr. JAMES. As I see it, there are two different problems. One is the population shift, and we're always behind because of the census. It's at least a year or so, depending on the estimates. Then you don't have an accurate count. It's only estimates and interpolations and only a relatively accurate count every 10 years. It geometrically affects us negatively when you have to wait 10 years.

But the other problem that I perceive is—and I don't know if it's correct, but I think it is—is that because you're basing it on the census, it doesn't account for the people that are here three to 6 months. It does show in your total count of services rendered, but when it comes to certain portions of the formula, the allocation is not reflected in that instance. Is that a fair observation?

General PECK. It is. I think we need a more fluid and dynamic system for resource allocation which can take care of that problem, so that when the gentleman comes down here from Michigan to spend the winter in St. Petersburg, in the age of computers, certainly we can keep up with that problem so that the change in demand is reflected almost instantaneously rather than over a 10 year period waiting for a new census or counting 5,000 in December or 2,000 in August.

Even if we just did it on an average, we would be better off than we are now. If we simply took that 3,600 a month and said Florida deserves that much each month in new resources, we would be better off than we are now.

Mr. JAMES. Because the veterans are entitled to the same benefits as if they're a resident.

General PECK. They should be entitled to it. They simply don't get the same benefits here as they do other places.

Mr. JAMES. But all veterans are treated alike, regardless of whether they're a resident or a visitor.

General PECK. That's right. There's no distinction there.

Mr. JAMES. Thank you very much for your testimony. You've been a great help.

Mr. EVANS. I have just one final question on a flexible allocation. Have you made recommendations to the Department of Veterans Affairs, and if you have, what has been their response?

General PECK. Not in those precise terms. I have sent a letter to Secretary Derwinski urging him to reconsider resource allocation plans. As a matter of fact, I have a meeting with Secretary Derwinski on Monday and I will reiterate what I have told you here this morning.

Mr. EVANS. Thank you very much, General, for your very interesting testimony before the subcommittee.

General PECK. Thank you.

Mr. EVANS. Our next witness is Donald Thompson, Regional Director, Southeast Region, Veterans Health Service and Research Administration. Don Thompson is accompanied by Dr. David Lowenthal, Director of the Geriatric Research, Education and Clinical Center at the Gainesville VA Medical Center. Dr. Lowenthal will not present a statement, but is prepared to respond to questions.

As Regional Director for the Southeast Region, Don Thompson is responsible for VA medical care operations at 22 VA medical centers, 13 satellite outpatient clinics, and 24 veterans centers in a seven-State area. We welcome you both today.

Don, we also have your statement and it will be included in the record in its entirety. You may summarize or proceed as you wish.

STATEMENT OF DONALD B. THOMPSON, DIRECTOR, SOUTHEAST REGION, VETERANS HEALTH SERVICE AND RESEARCH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY DAVID T. LOWENTHAL, DIRECTOR, GERIATRIC RESEARCH, EDUCATION AND CLINICAL CENTER, GAINESVILLE, FL.

Mr. THOMPSON. Thank you, Mr. Chairman.

Mr. Chairman and members of the subcommittee, thank you for the opportunity to appear to discuss the provision of extended care services to Florida veterans by the Department of Veterans Affairs.

As you mentioned, you have my formal statement, so I will simply try to summarize it at this time.

The Department of Veterans Affairs provides health care services in five medical centers and nine satellite clinics here in Florida. Each of these facilities provides a variety of extended care programs, both institutional and noninstitutional. They serve a 1990 veteran population of approximately 1.5 million people, of whom 34 percent are 65 years of age or older. By the year 2000, as you've heard, we expect that 45 percent of the population will be over the age of 65.

Further, the numbers of 75 and older veterans in Florida will triple by the year 2020, impacting not only our long-term services, our nursing homes and our community programs, but also demanding that we maintain services to deal with the recurrent episodes of acute care.

We currently operate 2,656 hospital beds, 830 nursing home beds, and 200 domiciliary beds in Florida. We are continuing to expand services with a 120-bed nursing home unit under construction at

this time at the VAMC in Tampa. Another nursing home has now been budgeted for 1991 and is to be located at Lake City, 120 beds. We will be breaking ground on a 400-bed medical center and a 120-bed nursing home at West Palm Beach, FL, scheduled this fall, somewhere around Veterans Day, appropriately. And in 1992, a 290-bed psychiatric addition will be built at Gainesville.

Preliminary planning is also in progress at this time for a medical center and nursing home in East Central Florida, the site of which has yet to be determined. Nursing home units are scheduled for Orlando and Fort Myers, to be built in conjunction with outpatient clinics which are currently operating but need to be relocated. Finally, another satellite clinic is planned for Tallahassee.

In 1990, we expect to treat 54,400 inpatients in our hospitals, and 1,838 patients in our nursing home care units. We will also provide community nursing home care for an additional 1,900 veterans. Our outpatient workload will be 1.2 million visits. These programs will all expand as these new facilities that I mentioned come on line, and by the year 2005, we project as many as 1.8 million outpatient visits.

We will provide domiciliary care for 606 veterans this year at Bay Pines, according to plan. In addition, we're going to provide per diem assistance to the veterans placed in the new Florida State Veterans Home Domiciliary in Lake City that was described by General Peck. In that arrangement, we contribute to a portion of the cost of construction and then we pay a per diem rate of $9.33 for veterans whose income is at or below $10,800 a year.

We have a wide range of noninstitutional programs, including hospital-based home care, at each hospital except Lake City; adult day health care treatment programs at Miami and the Daytona Beach outpatient clinic, and we have community residential care programs at all five of our medical centers.

In Florida, we have the Geriatric Evaluation and Management units, which we call GEMs, at Gainesville, Lake City, Miami, and a fourth unit is planned at this time for Bay Pines. Now, these units provide an interdisciplinary approach to comprehensive diagnostic treatment and discharge planning for elderly patients who typically have multiple medical and psycho-social problems. Gainesville also has the Geriatric Research, Education and Clinical Center, which is funded at a level of approximately $1.2 million, and has a primary research focus in geropharmacology.

In Florida, our medical centers provide care to veterans on a priority basis to service-connected veterans, special category veterans—such as ex-prisoners of war, victims of ionization radiation, Agent Orange and so forth—and certain non-service-connected veterans who are in receipt of pensions or whose incomes fall below a means test criteria level. Veterans who are insured, or whose incomes exceed criteria on the means test, or who can otherwise afford the cost of their care, are given the lowest priority and may be treated on a space and resource available basis, subject to billings and/or copayments.

In summary, the Department of Veterans Affairs has taken steps to meet the increasing demand for care through expanded programs, new facilities and new hospital alternatives. In my perspective, I believe Florida has continued to receive additional resources

to meet the needs of the growing population, but more are required.

That concludes my statement.

[The prepared statement of Donald B. Thompson appears at p. 52.]

Mr. EVANS. Thank you, Mr. Thompson.

I have a variety of questions, and I will proceed for about 5 minutes and then yield to the gentleman from Florida and then I may have a second round. I also want to pose on a few questions for Dr. Lowenthal.

On page 2 of your statement you reported a dramatic increase in demand for health care services for the elderly has occurred and is expected to continue. Can you give us specifics of both the increased demand which has occurred and is expected in the future and what additional resources will be needed to meet these increases in demand?

Mr. THOMPSON. Well, as I believe you mentioned earlier, Mr. Chairman, we know that the use of our facilities by veterans 65 and older particularly, or any person of advanced age, has a tendency to be between three and four times the use rate of veterans below that. We have seen an increasing impact throughout Florida—in fact, throughout our entire system—as the general population ages. These data are based upon our customary use patterns that we use in our planning process. We have good evidence that the growth is here and will continue to be here.

Mr. EVANS. Do you know how much this is going to cost? Are you projecting that cost and requesting it in your budgets from the DVA?

Mr. THOMPSON. No, sir. I have no long-range projection of the actual cost that this is going to produce because it will be based upon, of course, what the cost of the care is each year. I can say that, essentially, over the last 10 years, our budget has risen, on a national basis, approximately, from $9 billion to the 1991 level of about $12.2 billion. In Florida alone, we have increased the resources by over a billion dollars since 1983. That still isn't enough. We could certainly extrapolate those figures and produce them for you for the record.

Mr. EVANS. We would appreciate those figures. It would be very useful.

(Subsequently, the Department of Veterans Affairs furnished the following information)

Strategic planning projections for Florida VA facilities show that workload will increase significantly between FY 1990 and FY 2000, as shown below:

	1989	1995	2000
Hospital Census	1,900	2,954	3,397
VA NHCU Census	782	1,368	1,482
Community NH Census	462	825	1,162
VA Dom Census	178	180	180
Outpt Visits	1,190,764	1,573,080	1,787,900

Assuming constant dollars, the operating cost of this planned increase in Florida VA workloand would increase from $446,492,000 in FY 1989 to about $772,959,000

by FY 2000, a 73 percent increase. This operating cost does not include the cost of new construction and other non recurring costs.

Mr. EVANS. Congressman James' statistics, that 48,000 veterans come into this State each year, average out, although I'm not sure it's true for every month, to over 4,000 veterans per month. Are we able to project, knowing the numbers that are coming to the State, where they're going to live, where they're going to demand the services and so forth? Is there a model that we can use in projecting that?

Mr. THOMPSON. We utilize data that's provided by the State of Florida as far as their population trends. Essentially, we know the counties of specific growth. We have estimates by county and by age group for veterans. I could provide those also for the record.

Mr. EVANS. Well, at least an explanation of how that works in a brief form would be useful for my understanding.

(Subsequently, the Department of Veterans Affairs furnished the following information:)

During the 12-month period from 4/1/88 through 3/31/89, an average of 2,850 veterans moved to Florida each month. However, taking into consideration the Florida veteran death rate, there was an average net change of +1,500 veterans in Florida each month during this period. Data for the entire 12-month period is shown below:

+34,175 Veteran Migrants to Florida
-29,890 Veteran Deaths in Florida
+13,723 Released Active Duty Remaining in Florida

+18,008 Net Change in Florida Veterans

The VA Office of Information Management and Statistics provides updated current and projected veteran population estimates, by age and county, on an annual basis. These population data are incorporated into facility-specific projection models used to estimate future requirements for hospital beds, outpatient visits, nursing home beds, etc. Descriptions of the projection models follow.

The *hospital bed sizing model* projects future bed requirements for each facility based on current use rates by age group. The data used in the computer-generated model include: 1) the current and projected veteran population, by age group, in the facility's primary service area (PSA); 2) the facility's most recent discharge rates (ie, last 3 years), by bed section and age group; 3) the facility's most recent lengths of stay, by bed section and age group; 4) results of the facility-specific Appropriate Location of Care (ALOC) survey, by bed section; and 5) Program Interaction Adjustments to account for the impact of future outpatient and nursing home programs on hospital utilization. The model is essentially a linear projection based on current age-specific utilization rates applied to future population estimates, by age group.

$$\frac{\text{Projected Discharge Rates X Projected Lengths of Stay X Projected Veteran Population}}{\text{355.25 Days X Occupancy Rate}} = \text{Projected Beds}$$

For each bed section and age group, the model uses the most current year's discharge rate if there is a 3-year downward trend, the mean if there is no trend, and 110 percent of the most current year's discharge 'rate if there is a 3-year upward trend. The model uses the most current year's average length of stay if there is either an upward or downward 3-year trend; it uses the mean length of stay if there is no trend. The model then projects the number of acute and extended hospital beds needed at the VA medical center in the future, assuming standard occupancy rates (85% for acute bed sections and a 95% for extended care bed sections).

Community lengths of stay standards (by DRG, ICD-9 code, race, and mortality) are used to determine acute hospital bed requirements. VA lengths of stay exceeding these community standards are designated as "non-acute" beds. A percentage of the non-acute beds are retained as extended care hospital beds based on results of

an Appropriate Location of Care (ALOC) survey conducted, by bed section, at each VA medical center.

Like the bed model, the *VA outpatient model* projects future visits on historic utilization experience. Projected visits are derived by applying current (ie, the last 3 years) age-specific visit rates to future veteran population estimates, by age group, within the facility's primary service area. (Current visit rates are calculated by dividing the number of visits within each age group by the PSA veteran population for each age group.) The PSA veteran population used for a satellite clinic is the same as that used for the parent VA medical center.

$$\frac{\text{Visits by Age Group}}{\text{Veteran Population by Age Group}} = \text{Visit Rate}$$

Three-year mean visit rates, by age group, are used for projecting future visits unless the most recent year's visit rate is greater than the first year's visit rate, in which case the projected visit rate is 120 percent of the most recent rate. Outpatient visits are added for those hospital inpatients who, according to the Appropriate Location of Care survey, would have more appropriately been seen as outpatients. The total visits are then distributed among several Purpose of Visit (POV) categories.

The *VA nursing home model* is based on the premise that veterans require nursing home care at the same rate as do male civilians. Age-specific nursing home utilization rates in each census region are derived from a '1985 National Nursing Home Survey, conducted by the National Center for Health Statistics. These age-specific use rates, by census region, are applied to the projected veteran population in the facility's primary service area to estimate the future veteran demand for nursing home care.

$$\frac{\text{Male Civilians in Nursing Homes}}{\text{Male Civilians in Gen. Population}} = \text{Utilization Rate}$$

Utilizaton Rate X Veteran Projected Vet. Population = Veteran Demand

The VA methodology assumes that the VA will sponsor a 16 percent market share of the total veteran need; this market share will be treated in VA-operated nursing home beds, community beds at VA expense, or state nursing home beds. The planning goal for the VA-sponsored bed mix is 30% VA, 40% community, and 30% state nursing home beds.

Veteran Demand X Market Share = VA Sponsored Demand

VA Sponsored Demand X 0.30 = VA Census
VA Sponsored Demand X 0.40 = Community Census
VA Sponsored Demand X 0.30 = State Home Census

Mr. EVANS. According to your testimony, the VA estimates 11,000 veterans in Florida will require nursing home care this year, but only 16 percent of these veterans will be served by the VA. In other words, the VA will not be able to provide extended care to 84 percent of the veterans in Florida who need it. Is that correct?

Mr. THOMPSON. That's correct, sir.

Mr. EVANS. Then what criteria are used by the Department of Veterans Affairs to select the veterans who, in fact, will receive that nursing home care?

Mr. THOMPSON. Essentially, what it's boiling down to is those people who are service-connected or those people who have been hospitalized within the VA hospitals and are non-service-connected and placed into the nursing homes for a period of time. But basically, it's on the same priority basis that we use for admission to hospitals. It starts at the top with service-connected and works down to as long as the space is available.

The position that we're faced with is that the admission for non-service-connected veterans is considered to be nonmandatory and we take care of those workloads that we consider mandatory first.

Mr. EVANS. Are there any service-connected veterans that are not being served?

Mr. THOMPSON. I would hate to give you an answer that said there are absolutely none that are not being served. I would suspect there are some veterans who could use nursing home care that are not getting it, but there would be a variety of reasons for that. It would not be a matter of policy or operational intent that that would occur.

Mr. EVANS. I also understand that although the policy is to provide extended care to at least 16 percent of veterans who need it, that in this State even fewer veterans, percentage-wise, are being provided that care. I understand this care is only being provided to about 12½ percent of the veterans in the State who need it. Is that correct?

Mr. THOMPSON. That's correct. Part of the problem is the way the formula is arrived at. This is a negotiated formula, as I understand it, through the Office of Management and Budget. Essentially, it was a recognition that resources were not available to provide nursing care for everyone. So——

Mr. EVANS. Could I interrupt you there? It was a recognition by OMB that the resources weren't going to be there, or a joint agreement——

Mr. THOMPSON. I believe a joint agreement, sir.

Mr. EVANS. All right. We want to find out the root of this problem.

Mr. THOMPSON. You know, it's also based upon a split of 30 percent VA, 40 percent community, and 30 percent State. As General Peck mentioned, the State of Florida, as of right this moment, has no State facilities, so we can't expect to place anyone in a State facility until one is available. But we still have to factor our total nursing home care load on the basis of that formula. The truth of the matter is, we only reached about 78 percent of the level that we should have provided this year in VA facilities.

Mr. EVANS. In response to the General's statements about the newly authorized commitment by Florida, is that going to help you in dealing with the Office of Management and Budget in seeking further dollars?

Mr. THOMPSON. I would certainly think so.

We've had a number of nursing homes on the books, as I mentioned, and I went down the list of those that have been planned. At one point in time they were further advanced in the budget process. There's been an effort to make certain that the Department of Veterans Affairs utilizes underutilized beds for conversion to nursing home units. That has also contributed to our problem because we don't have the vacant beds to convert to nursing home care units. It doesn't do us any good if there are vacant beds in North Dakota when we need the nursing home beds here. But that's another thing that is being dealt with on a policy level and I'm not privy to where those negotiations may stand at this point in time.

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I do know that Secretary Derwinski has said that he firmly believes that equity of access is a viable goal in resource distribution, and resource distribution would also include facilities.

Mr. EVANS. My 5 minutes has expired. I would like to come back for a second round of questioning and ask some questions about the GRECC and what it does. But let me at this time yield to Congressman James.

Mr. JAMES. Thank you so much, Mr. Thompson. Your testimony is certainly enlightening. I have just a few questions.

You say the formula breaks down to 40/30, and the 30 percent is——

Mr. THOMPSON. It's 30 percent in VA owned nursing homes, nursing home care units, 40 percent in the community nursing home program, and 30 percent in the State. That's the way the formula is divided.

Mr. JAMES. In which area did we not fill up the——

Mr. THOMPSON. We didn't actually fill it, the full level, in any of those areas.

Mr. JAMES. Let's compare it with any other State. We're picking up presumably Congressmen and other States are losing Congressmen. New York, for example, or New Hampshire or Maine, what percentage are they able to——

Mr. THOMPSON. It's my understanding that no one is actually meeting this formula. You know, it's predicated on a switch of their resource commitment from the Federal Government to the State, and that has been a problem for some of the States. Some States have multiple nursing homes in them and others still, to this day, have none. Florida is making a remarkable effort in a short period of time——

Mr. JAMES. And in what percentage is this State participating?

Mr. THOMPSON. What did we actually have in nursing homes?

Mr. JAMES. Yes.

Mr. THOMPSON. We had none in State nursing homes.

Mr. JAMES. There are none?

Mr. THOMPSON. There are no State nursing home beds as yet.

Mr. JAMES. So we don't have any of that 30 percent?

Mr. THOMPSON. That's right. None of that 30 percent is being attained.

Mr. JAMES. And in the community, what percentage of the 40 percent are we using?

Mr. THOMPSON. In the community—well, let me try to go over the figures. We project the need in the whole State of nursing home care by approximately 11,000 veterans. Our 16 percent would compute out to 1,761 beds. By the year 2000, our 16 percent would require beds for 23,212 veterans, which is more than twice the 1990 estimate. We would then need to provide 1,114 VA nursing home beds this year, which is 202 above the level of beds that we have at this time. We would have to double our community nursing home program and we would have to have a census of 1,114 in State facilities. So we're far below it.

Mr. JAMES. We have, say, 12.5 percent. What's the average in other States?

Mr. THOMPSON. I don't have that documented. I can try to find it. Some of these statistics are really kept very well, but I'll see if I can find out.

(Subsequently, the Department of Veterans Affairs furnished the following information)

VA-sponsored nursing home utilization in FY 1989 decreased both in Florida and nation-wide. All of the decrease occurred in community nursing home census because community nursing home funds were not earmarked in FY 1989 and the hospitals used these funds to make up budgetary shortfalls. (Community nursing home funds are once again earmarked in 1990.) Thus, VA-sponsored nursing home utilization nation-wide dropped from 19.0 percent in FY 1988 to 16.8 percent in FY 1989; VA-sponsored nursing home utilization in Florida dropped from 14.0 percent in FY 1988 to 12.6 percent in FY 1989. The specific mix (average daily census) is shown below.

	FY 1988		FY 1989	
Florida				
VANH Census	778	60%	782	63%
CNH Census	516	40%	462	37%
SNH Census	0	0%	0	0%
	1,294	100%	1,244	100%
Nation				
VANH Census	11,344	35%	11,468	39%
CNH Census	12,405	38%	9,305	31%
SNH Census	8,666	27%	8,996	30%
	32,415	100%	29,769	100%

Florida continues to have the lowest nursing home utilization rates in the nation. This is due, in part, to the fact that Florida has no state nursing home beds.

Mr. JAMES. If I'm service-connected disabled and I live in the State of Florida, and I have $4,000 in income and need nursing home care, how soon could I expect to have a bed?

Mr. THOMPSON. I'm sorry. Did you say you were service-connected?

Mr. JAMES. I'm service-connected, I have $4,000 in total income from Social Security or whatever source. That's it, no assets.

Mr. THOMPSON. If you're service-connected and the service connection—the condition that is service-connected is what would get you into the nursing home or is what you would be admitted for, you shouldn't have to wait long.

Mr. JAMES. I'm saying there's no question but that I'm service-connected, okay? I need nursing home care and I have no money. I have a $4,000 income. How quickly can I have a bed?

Mr. THOMPSON. I'm really not certain what the waiting times are on each of the nursing homes. I would have to go to each nursing home for that.

Mr. JAMES. If I made $12,000, let's say, above the $10,000 figure that's in your testimony, and I'm service-connected, could I reasonably expect to ever have a bed?

Mr. THOMPSON. Well, if you're service-connected, your level of income has nothing to do with it. That only applies to the non-service-connected. The $10,800 is the level established as the poverty level for admission and support by the VA in a State home. So they are two slightly different things.

Mr. JAMES. In this State, suppose I had no income and I'm not service-connected and it's clear I need nursing home care, but I have no income, or very minimal income. How soon could I expect a bed?

Mr. THOMPSON. First of all, you would have to be admitted to a VA hospital for treatment first, and then discharged to the nursing home. If you had no income, of course, you would be entitled on a resource available basis. It would really depend upon the availability of beds.

Mr. JAMES. How would I get into a hospital if I'm not service-connected in this State?

Mr. THOMPSON. That's also a problem. If you have no income, then you will be in Category A and, therefore, you would have priority admission. Category A with no income, non-service-connected with no income, is Category A. In other words, you could not exceed the criteria for the means test. Therefore, you would be admittable to the VA.

Mr. JAMES. Just like a service-connected veteran, the same level?

Mr. THOMPSON. Yes. Yes, you would be entitled.

Mr. JAMES. If I had two or three thousand income, it would have to be up to ten, wouldn't it, to——

Mr. THOMPSON. Actually, it's the minimum pension rate established by the Veterans' Administration. I think it's $17,240, in that general neighborhood.

Mr. JAMES. Thank you so much for your testimony.

Mr. EVANS. If I were that veteran, how long would I be entitled to nursing home care after I was admitted?

Mr. THOMPSON. Well, if you were admitted to a VA unit and your condition was such that your need was a long-term prospect, you would stay there as long as you needed the care, or until some other alternative could be supported and be found. We place the greatest number of our non-service-connected people in the VA units and we utilize the community nursing home program somewhat for our service-connected. The reason for that is, under the rules that govern the community nursing home program, a service-connected veteran has unlimited eligibility, whereas a non-service-connected veteran has only 6 months. And that's the maximum.

Mr. EVANS. I have many other questions, and will ask a few more. Additional questions may be submitted and we would ask that you respond in writing.

Mr. THOMPSON. I would be pleased to do so.

Mr. EVANS. Then those questions and your responses will be made a part of the record.

A later witness will testify that the VA's community nursing home per diem rate is inadequate and that a higher per diem rate is the key to more community nursing homes participating in the VA program. Do you agree or disagree with that notion?

Mr. THOMPSON. That varies around the system and varies from county to county as a matter of fact. It's interesting that we are in the process now of developing a mechanism by which we will reimburse nursing homes at the Medicaid rate plus 15 percent. Those procedures are still being developed in Washington and have not been disseminated to the field, so I really don't know how that will impact the situation.

Our average per diem is approximately $78 a day now that we're actually paying here in Florida.

Mr. EVANS. A VA circular issued in January called for establishing VA liaisons with State nursing home rate-setting bodies. Has this been done in Florida and, if not, why not?

Mr. THOMPSON. I certainly should know that, but I don't. I will have to find out the answer to that.

Mr. EVANS. All right. If you could provide us the answer, we would appreciate it.

(Subsequently, the Department of Veterans Affairs furnished the following information)

Circular 005-90-1, "Community Nursing Home Care Per Diem Rates" dated January 5, 1990, was published by the Assistant Secretary for Acquisition and Facilities. It was directed to Heads of Contracting Activities. Its purpose was to provide policy direction for negotiating nursing home contract rates with community nursing homes.

This circular called for the establishment of a single point of contact for the entire state for liaison with the state Medicaid rate setting body. The purposes were to develop a professional relationship, obtain documentation regarding services covered by state rates, determine the composition of state rates (particularly the manner in which profit is allowed), identify available labor rate information, and obtain information on the census of Medicaid patients. All this information was to be disseminated to all medical center contracting officials within the state for use in contract negotiations.

As required by the circular, two members of the Acquisition and Materiel Management Service at the Lake City, Florida VAMC met with officials of the State of Florida Department of Health and Rehabilitative Services in Tallahassee, Florida on May 8, 1990. Liaison was established and the information required by the circular was obtained. This information was disseminated to the Chiefs of Acquisition and Materiel Management Services at each of the other Florida VA Medical Centers, as well as the Montgomery, Alabama VA Medical Center, on May 17, 1990. Therefore, all Florida VA Medical Centers have the information required by the circular for use in negotiating community nursing home per diem rates with individual community nursing homes as the individual contracts are renegotiated.

Mr. EVANS. Has a formal geriatric program been established at every VA medical center in Florida and, if not, why not?

Mr. THOMPSON. A formal geriatric center? No, I would say——

Mr. EVANS. A program, either in a geriatric section, a GRECC or another program. Maybe Dr. Lowenthal could better answer that.

Dr. LOWENTHAL. Mr. Chairman, the only formal geriatric program within the State of Florida is at Gainesville.

Mr. EVANS. Well, let's start with some questions on the GRECC. I think it would be useful to make sure everyone understands what a GRECC is. It's a Geriatric Research, Education and Clinical Center. I have to look at a piece of paper to get that down myself.

Now, can you tell us what the impact of the Gainesville GRECC has been on the quality of geriatric care here in Florida?

Dr. LOWENTHAL. Sure, Mr. Chairman. I'll do my best.

The quality of care for patients is related to all three components—the research, education and actual clinical care. But let me address the latter first.

The clinical care is centered about the Geriatric Evaluation Unit, which is a 24-bed inpatient unit at the Gainesville VA. We have patients who come in for rehabilitation, for respite, for hospice, for evaluation of various problems that are common to the elderly patient, veteran or not, and then, once the patient is discharged either to an extended care facility or to home, the patient is followed by a staff skilled in geriatric medicine.

The patient could be followed in the outpatient clinic at the VA in a specific geriatric section; the patient could be followed by the hospital-based home care, which is something that was alluded to in earlier remarks, where in the geriatric physicians actually make house calls and are an extension of the care provided within the hospital system. The clinic care extends as well into the nursing home where our geriatric staff houses that particular management system.

To my dismay, 30 beds within the Gainesville VA nursing facility have been closed. One-hundred and twenty was the total, and now it's down to 90 operational beds. This was part of the consequence of the budgetary cutback. Hopefully, these will reopen at some point in time. But that buttresses some of the comments that have been made about some significant cutbacks in VA expenditures for health care, and it has impacted on our total program as well.

The second area which impacts on patient care is through education. The education is to medical students with whom we are very closely allied at the University of Florida College of Medicine, where I'm a professor of medicine, pharmacology, and exercise science. The education is extended to the trainees in medicine who also rotate through the geriatric program. Education is at the postgraduate level to physicians in the community, and education is provided to the paramedical health care providers such as nurses, social workers, psychologists, nutritionists, dieticians and so on.

We have also instituted an education program to people in the community. Since my coming to the Gainesville VA in November of 1988, I thought that the residents in the community deserved some input into what the ramifications are with regards to drug therapy in the elderly, where polypharmacy is rampant, with the expenditures for drugs so costly, being involved in clinical pharmacology, especially as applied to geriatrics, I thought this was necessary to provide for, over a year's period of time—this is extended well beyond a year—a monthly visit to various senior citizen groups at their monthly meetings, and provide an in-service discussion, if you will, about drugs and the problems of medicines in the elderly. So that this impacts on quality care as well.

Mr. EVANS. Also, the GRECC is established to do research. Could you briefly tell us about its research activities?

Dr. LOWENTHAL. Certainly, Mr. Chairman.

The research program is at the basic level, at the bench level, looking at various mechanisms related to the aging cardiovascular system, the aging nervous system. The research is applied clinically in my own area of pharmacology, especially with regards to high blood pressure, with regards to heart disease, and we also have a very big program in exercise for the healthy and unhealthy patient population. This includes veterans as well as nonveteran elderly citizens.

The education program impacts on the research. The research impacts on the clinical. So I view the entire GRECC program as an equilateral triangle, where education, research, clinical care, all interdigitate, all weave together. It's a massive team effort that hopefully is being carried out appropriately.

I might mention for the record that the GRECC is one of 12 such entities throughout the United States. The Congress has anticipat-

ed increasing this to 25 GRECC centers throughout the country. These are all allied to the respective medical schools that are associated with these VA institutions.

The emphasis at each GRECC is a bit different. One may focus on diabetes, one may focus on heart disease. Ours focuses on pharmacology or drug research and drug therapy for various disease entities that the elderly have.

Mr. EVANS. How long has it been in existence?

Dr. LOWENTHAL. The GRECC has been in existence since 1985.

Mr. EVANS. We thank you both. I don't know if Congressman James has any other questions.

Mr. JAMES. Just one question area.

Of the 30 beds that were closed, whose decision was it to close those? It was based on funding, but whose decision was it?

Mr. THOMPSON. It was the decision of Mr. Malcomb Randall, the Director. It was based on funding and nursing shortage.

Mr. JAMES. Was it Federal funding?

Mr. THOMPSON. Yes, sir.

Mr. JAMES. As opposed to any other collateral issue.

Mr. THOMPSON. That's right.

Mr. JAMES. So we lost 30 geriatric beds out of 120?

Dr. LOWENTHAL. That's correct.

Mr. JAMES. So we lost 25 percent of the geriatric beds in the State of Florida?

Dr. LOWENTHAL. If that reflects the total number of beds within the State of Florida, if that's your premise, that's correct.

Mr. JAMES. I'm sorry. I may have misunderstood the testimony.

Mr. THOMPSON. I think it extrapolates out to that. But in reality, and operation, the beds closed but the patients weren't ejected from the hospital, or discharged. They were absorbed into other units.

The purpose of the closure of the beds was to reduce the operational cost. What they did was consolidate the nursing staff from that unit on to other units, theoretically, at least, giving you increased nursing capability on the remaining units and still treating the patients.

Some medical facilities, to this day, have not formulated geriatric units because their local philosophy is that each service should be involved in geriatrics and gerontology and, therefore, each service maintains a certain number of beds. Like Surgery will have some, and Geriatrics will have some. They're not clearly defined, as you were pointing out.

Mr. JAMES. In other words, you reallocated the resources to other nursing benefits. It's not as if you had a reduction of budget, but you decided to reduce those number of beds to expand the nursing home beds based on need?

Mr. THOMPSON. Well, it's a cumulative effect. As you well know, the Veterans' Administration, prior to the Department of Veterans Affairs, was in rather substantial financial difficulties in fiscal year 1988, particularly in the first part of the year. This was the result, in part, at least, from increased costs and also from 5 successive years of one percent productivity reductions in our budget. It was the net effect of that, plus the declining competitive position for recruitment of nursing staff. Our relative position has suffered

somewhat because our pay scale is somewhat below what is being offered in other sectors, particularly when you're talking about benefits packages. So we're tending to lose nurses.

This is a system-wide problem, not just Florida. As a matter of fact, it's much worse in some other areas. But it was a combination of things of this nature that caused the Director to say I must consolidate people into smaller spaces and try to turn the patients over more rapidly without decreasing the quality of care. That's the goal.

It would be nice if we could reopen that.

Mr. JAMES. Thank you very much.

As long as you're answering in this particular area, I'll ask one other question. What percentage of our veterans that we have in nursing homes are service-connected? First, what's the number, and then what percentage of them are service-connected and what percentage of them are not service-connected?

Mr. THOMPSON. Okay. I've got some backup material there that has that. Bear with me just a second.

In the community nursing home, 44 percent were service-connected in fiscal year 1989, and this year it's running 49.8 percent for service-connected. So it's approximately half.

I'm looking for discharges to our own nursing home units. I don't seem to have that with me.

Mr. JAMES. It would be roughly the same, then, in all probability?

Mr. THOMPSON. I would assume that it's roughly the same. It could be slightly higher on the non-service-connected in the VA units.

Mr. EVANS. Could you supply us with those statistics?

Mr. THOMPSON. Yes, I will.

(Subsequently, the Department of Veterans Affairs furnished the following information)

In FY 1989, there were 1,953 patients treated in Florida VA nursing home units; 42 percent were service-connected veterans and 58 percent were non service-connected. Of the 2,143 veterans treated in community nursing homes in FY 1989 at VA expense, 37 percent were service-connected and 63 percent were non service-connected.

Mr. JAMES. Thank you very much for your enlightening testimony, both of you.

Mr. EVANS. Thank you both. We appreciate it.

Next we are going to call a witness panel consisting of representatives from veterans' organizations. The panel members are Brian Terwilliger, Dennis Cullinan, who is accompanied by William Kirsop, and Mr. Clyde Cleveland. If you all would come forward and be seated, we would appreciate it.

Brian is the National Director of the Paralyzed Veterans of America, Central Florida Chapter. He is a Navy veteran.

Dennis is the Assistant Director, National Legislative Service, Veterans of Foreign Wars. He is accompanied by William Kirsop, Florida State Service Officer. Bill is retired from the Air Force, following 21 years of service.

Clyde Cleveland is the Volusia County Veterans Service Officer, Department of Veterans Affairs. He served 4 years in the Navy and retired after 22 years of service in the Army. He is very highly

decorated and his decorations include the Legion of Merit, the Bronze Star with v device with two oak leaf clusters, the Air Medal with oak leaf clusters, the Army Commendation Medal with oak leaf cluster, Meritorious Service Medal with oak leaf cluster, the Vietnam Cross with oak leaf cluster, and the Purple Heart. That is quite a lot of "fruit salad" on your chest. We appreciate all of your service to our country.

Brian, we'll begin whenever you're ready.

STATEMENT OF BRIAN TERWILLIGER, NATIONAL DIRECTOR, CENTRAL FLORIDA CHAPTER, PARALYZED VETERANS OF AMERICA

Mr. TERWILLIGER. Mr. Chairman and members of the subcommittee, on behalf of the members of the Paralyzed Veterans of America, I wish to thank you for holding this hearing today and for inviting us to testify concerning the provision of extended health care to veterans in the State of Florida.

At the outset, PVA believes that continued underfunding is eroding the ability of the VA health care system to provide entitled needy veterans access to appropriate extended care and other medical services both in Florida and across the Nation. This problem arises primarily in the provision of outpatient, long-term, and nursing home care for veterans with Category A entitlement. As you know, although such medically indigent, non-service-connected veterans have clear entitlement to all inpatient treatment at VA medical centers, many of them are not entitled to outpatient care or extended care.

Because of ambiguities in health care entitlement, hospital administrators must ration or redirect care when resources are not available. There is no question that such restrictive health care contradicts the current emphasis on outpatient and extended care. It is certainly not in the best interest of the comprehensive health care needs of a patient or group of patients to be denied outpatient or extended care based on variable and financially motivated eligibility decisions. PVA strongly supports legislation that would provide Category A veterans with entitlement to the full array of VA health care services—inpatient, outpatient, and all extended care, including nursing home and long-term care.

I wish to emphasize our belief that noninstitutional forms of extended care must be maximized to every extent possible. These forms of care are generally less expensive than institutional care and maximize the veteran's independence. In addition, the increased development of extended care programs away from the hospital setting will complement VA's large institutional care programs already in place.

In Florida, as in most States, any level of funding can bring extended care to more veterans if it is used for noninstitutional, long-term care rather than institutional care. Since insufficient funding in recent years has prevented VA from expanding extended care programs on a noninstitutional basis, we believe it is essential that VA be provided with sufficient funding to meet the demands of the aging veteran population, a population which is growing much faster than the general population.

Regarding institutional settings in our region—Florida, Georgia, South Carolina and Alabama—we believe the VA is in an excellent position to further develop centers dedicated to geriatric and long-term care. Secondary care hospitals, in proximity to tertiary referral VA medical centers, represent ideal locations for long-term care through conversion of beds and mission. With the existence of such centers, veterans could have increased access to facilities which would provide a nursing home, geriatric evaluation units, ambulatory clinics, an adult day care center, a home care team, a respite program, and a hospice program. We believe the VA must develop this strategy of multilayered, long-term care facilities in each VA medical region across the country.

We also encourage VA to expand its home-based health care program in Florida. HBHCs allow the early discharge to their own homes of chronically ill veterans who are generally expected to remain bedbound or housebound. HBHC also reduces readmissions to the hospital and has been shown to be extremely cost-effective. We believe it is critical that every VA medical center in Florida expands and improves the HBHC concept.

Extended care to an aging veteran population must also include respite and hospice capabilities. Respite care will enable elderly and disabled Florida veterans to be institutionalized periodically to allow a relief period for the spouse or relatives who normally care for the patient. This relief from responsibility reduces the strain upon care givers and they remain willing and able to provide care for the veteran, who thus avoids institutionalization for a longer period. VA medical centers can make use of temporarily empty hospital beds and the care staff associated with such beds. The net program cost is little more than the staff time required for its coordination.

Mr. Chairman, as you know, hospice programs enhance the quality of life for terminally ill veterans. Through the use of the HBHC team, the program allows many veterans to remain at home among familiar surroundings and family. We are hopeful that Florida VA facilities will plan to maximize the use of hospice programs to include inpatient care for terminal patients during periods when they cannot be cared for at home.

Because of the large number of elderly veterans living in Florida, we are very interested in VA's Geriatric Research, Education and Clinical Centers. We strongly encourage VA to integrate, to every extent possible, expanded GRECC programs in Gainesville, FL and throughout the VA health care system. As the veteran population grows older, the VA will be better able to deal with problems of the aging and develop new approaches of care for this group.

Finally, VA must continue to increase the nursing home care census in Florida, as well as nationwide. Despite our recommendation for major expansions of noninstitutional extended care, an increase in institutional long-term care also remains necessary to serve the growing number of veterans who have such severe functional limitations that they cannot be cared for in a noninstitutional setting. We understand that VA plans to increase nursing home capacity in Florida from 1,859 beds to 2,220 beds by the beginning of 1995, as well as the inclusion in their strategic planning

of major construction projects for nursing home care in Lake City and Tampa over the next 4 years.

Mr. Chairman, we believe our State must lead the way in providing the latest extended care concepts for our rapidly aging veteran population. We hope to work closely with you and our various Representatives to ensure that Florida veterans and all veterans receive the best possible health care that we, as a Nation, can offer.

That concludes my testimony. Once again, I wish to thank you for coming to Daytona Beach today to hear our views on the issue of extended care. We sincerely appreciate your concern for the well-being of this important program.

[The prepared statement of Brian Terwilliger appears at p. 58.]

Mr. EVANS. Thank you, Brian, very much. We appreciate your testimony.

Mr. Cullinan.

STATEMENT OF DENNIS CULLINAN, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. CULLINAN. Mr. Chairman, on behalf of the VFW's 2.2 million members, I wish to deeply thank you and, of course, Congressman James, for holding today's most important hearing. That VA should be fully able to provide for this Nation's veterans' current and future health care needs is a VFW priority goal. We are, therefore, highly gratified at being asked to participate in today's deliberations.

As you know, on a national level, veterans are aging far more rapidly than the general population. This means that VA must devise the means, methods and modalities needed to provide for the rapidly increasing and evermore expensive health care needs of an older veteran population. This is, of course, in keeping with VA's legal and ethical responsibility to care for those who fought and sacrificed on behalf of our national liberty in their time of need.

We view the locale of today's hearing as being most appropriate. Just as VA must prepare to provide for the health care needs of a large elderly population in advance of the Nation in general, VA health care in Florida will be among the first to meet this challenge within the VA system. Thus, just as VA must serve as the vanguard for the means of providing health care to veterans and, indirectly, the Nation, Florida, due to its unique demographics, will serve as a model for the entire VA health care system.

Mr. Chairman, it is now my privilege to introduce to you one of the VFW's most outstanding State service officers, Bill Kirsop. Bill is both highly conversant with the everyday working of VA in the State of Florida and very knowledgeable with respect to the special health care needs of Florida's veterans. Thank you.

Mr. EVANS. Bill, we also have your statement and we will make it part of the record. You may proceed in any way you wish.

STATEMENT OF WILLIAM R. KIRSOP, STATE SERVICE OFFICER, VETERANS OF FOREIGN WARS OF THE UNITED STATES, DEPARTMENT OF FLORIDA

Mr. KIRSOP. Well, sir, since this is the first time I've done this, I am going to use my statement to a certain extent. But I will cut it short. I would like the opportunity, if I could, to answer Congressman James' question that he asked Mr. Thompson, as a veterans advocate, when I'm finished.

Mr. EVANS. We will give everybody on this panel an opportunity, since you're our point people out here, to respond to some of the statements made earlier.

Mr. KIRSOP. Thank you for giving me the opportunity to come before you today as a member of the Veterans of Foreign Wars, Department of Florida. As the State Service Officer, I have first hand knowledge of the problems all veterans, particularly older veterans, are having regarding medical care in Florida.

Congress passed the means test several years ago. The intent of this law, we believe, was to ensure low income veterans would receive the necessary health care they needed. I have been informed by fellow service officers throughout the country that their low income veterans are continuing to receive outpatient health care.

This is not the case in Florida. The VA health care facilities in Florida are taxed to the fullest extent to supply health care for the service-connected veteran whose disabilities were a result of military service. Non-service-connected veterans are usually told to obtain care from the private sector because of budget and staffing problems. Many cannot afford to do so.

Continuing outpatient treatment for Category A veterans that are not rated 50 percent or more service-connected is virtually nonexistent in Florida. Veterans rated less than 50 percent service-connected make up a substantial amount of our veteran population. Many of these veterans have no where to turn. DVA realizes this problem because they came here today and told you about the problems, and the VFW and other veterans' organizations are continuing to make them aware of the problem. We know the only way the problem is going to be resolved is with additional allocation of funds and funds transferred, however you want to do it, reallocated to the State of Florida from other States where the veteran population needs are not as demanding.

The VFW wants the service-connected veteran to be treated first. We also believe that DVA should be required to treat all wartime veterans who cannot afford private medical care. There is a provision in the law which allows pre-bed care to be supplied by the VA to veterans to alleviate the need for hospitalization. Mr. Chairman, at the same time the non-service-connected veteran cannot get the medication he needs for his condition through the DVA. If you don't get medication, there's a good chance you're going to need hospitalization.

I know my private medical insurance—I'm one of those veterans who is fortunate enough to have private medical insurance—pays 85 percent for my outpatient visits, but it only pays 80 percent when I go in the hospital. Why? It's a lot cheaper to keep me out of the hospital. Outpatient treatment is the way to go.

I would like to read a letter that my organization has to send to veterans here in Florida. This one happened to be June 5, 1989. "We thank you for your letter concerning treatment at Tampa DVA hospital. Unfortunately, the migration of numerous veterans to Florida has resulted in approximately 70 percent of the veterans now living in Florida having service-connected disabilities. Under DVA laws and regulations, DVA hospital care is provided on a priority basis with service-connected veterans and lower income veterans having top priority. Although veterans with higher income may be provided VA health care, this is accomplished on a space available basis and the said individuals will be charged a deductible for their care based on their level of income. However, in cases of emergency, hospital care should be provided.

"The reason you were able to be treated in New Hampshire—or anywhere—was that the service-connected population is much lower in the northern States and space availability never posed a problem.

'Although I realize you may not be fully satisfied with the answers I have given you, the law clearly defines that, unless you're a Category A veteran or a 50 percent service-connected veteran, the chances of getting outpatient treatment in the State of Florida is nil."

It is a shame, sir, that this organization or any veterans organization has to make an excuse for the DVA. But we realize it's not always their fault.

At our VFW 90th national convention, seven resolutions were passed addressing DVA construction, staffing inadequacies in the DVA, Category A veterans entitlement to outpatient care—as my colleague from the PVA just talked about, and we're in total support to that—and guaranteed entitlement to nursing home care. They have been presented by our National Legislative Office to the House Committee on Veterans Affairs. Not one of these problems have been resolved here in the State of Florida.

On a positive note, the VFW periodically visits the VA hospitals. These are field representatives from our Washington office. I would like to go on record as saying that the last time we visited the Gainesville hospital, we were very much impressed with their Geriatrics Research (GRECC) program and what's going on up there. We visited it back in 1986 and several staffing changes were made since then. We feel the program has been turned around and we wish it continued success.

We would like to see the GRECC extended, in Florida, particularly to the medical center in Bay Pines. The reason is that Pinellas County has a large number of elderly veterans, so we would like to see it expanded, not only at Bay Pines but throughout Florida.

On the issue of nursing home beds, we talked about waiting lists and how long would it take to get into a nursing home. The waiting list for admission to our homes is not as lengthy as one may think. It's because current VA policy is to offer rehabilitative care and not extended care. This is so they can treat more patients. I believe that if DVA doubled their amount of nursing home beds today and offered full extended care to the elderly veterans in Florida, if they just doubled it, by the end of the month they would be filled up.

The VFW further believes that additional budgetary assistance should be provided to the DVA in the form of more capability to place veterans under contract nursing care. I remember in 1981, when I first started in this business, it was not unusual for a veteran to get 6 months extended care after he leaves the VA hospital. This is not done today. He's fortunate to get 60 days. Then they ask him to go elsewhere or for the family to take over the cost. Believe me, sir, that's impossible.

Mr. Chairman, thank you for giving me this opportunity.

[The prepared statement of William Kirsop appears at p. 60.]

Mr. EVANS. Thank you.

Mr. Cleveland.

STATEMENT OF CLYDE K. CLEVELAND, VETERANS SERVICE OFFICER, VOLUSIA COUNTY, FLORIDA

Mr. CLEVELAND. Mr. Chairman and members of the panel, I would like to thank Congressman Craig James for inviting me here this morning. I am the Volusia County Veteran Service Officer and I am the individual that sits across the desk from veterans who have complaints about VA medical service.

Most of the points that have been brought up this morning are in my testimony, but I would like to bring up a few problem areas that we see from day to day down in our area. For example, if an elderly veteran needs the aid and attendance of another person on a daily, self-care activity, and he can be supervised in taking his medication but prefers to live his life out in an ACLF rather than in a nursing home, due to limited funds, the VA will not consider ACLF fees for this nonreimbursed medical expenses. Therefore, they will not, creating a problem later on down the line and he's going to end up in a nursing home to end out his twilight years, costing the VA considerably more expense.

The means test that Mr. Kirsop talked about was devised to take care of the low income veteran. It has not succeeded. It has not done that because of restrictions that non-service-connected veterans can only be taken care of when the condition constitutes a life-threatening situation. Once the condition is chronic, then the VA will probably take care of him, if we can get him to a hospital.

Many of our older, non-service-connected veterans that have been through all the European Theaters and the Japanese wars and World War II and the Korean war were lucky enough not to get injured. They slept on the ground the same as the individual that got injured did, but for lack of being wounded or having some condition, not being incapacitated, they cannot receive the benefits. It's a shame, like Mr. Kirsop said, that we can't take care of these older veterans. If we could spend $50 worth of medication to keep him out of the VA facility the VA would save expenses incurred when major attacks occur.

Military retirees. The community of Daytona Beach has many retirees. There's a clinic 5 or 6 miles from here. We have served our country, and yet, we cannot get treatment at a VA facility. We have to drive 70 miles to Patrick Air Force Base or Orlando in order to receive treatment. I think some kind of a voucher system should be instated, but I keep hearing how complicated the system

would be to set up. If Master Card and Visa can do it, we should be able to do it with the VA. The VA already issues a card, and the active Army should be able to issue that type of card. It's just a matter of exchanging paper. Older veterans shouldn't have to drive from here to Patrick Air Force Base to receive treatment or get his medication. They should be able to go to a VA facility to get it.

Mr. EVANS. I assume there are a few more military retirees in the area other than just you two.

Mr. CLEVELAND. There are quite a few, yes.

[Laughter and applause.]

Another problem we have in the local area—and I don't know whether anything can be done about it—but if my wife called an ambulance to transport me to a local hospitals, and if the ambulance submitted a bill to my wife or to the hospital, if I could not afford it, the VA will not pay that ambulance bill until they find out the hospital's diagnosis of that individual veteran; and the admission is for a service-connected condition. If he's not in there for a service-connected condition, they will not pay that ambulance bill. Right now, the local EVAC office stated that the VA owes them a little over $18,000 for veterans that they've transported to a local hospital who couldn't afford to pay. I think somebody needs to look into those type of problems.

Service-connected veterans who have painful conditions that must be cared for immediately cannot get that assistance from the VA. Let me give you an example. Just this past week an individual came into my office and said he had to have a heart bypass. He was told by the VA hospital that it would be 12 to 14 months before he could get bypass surgery. I said no, we can't live with that kind of an answer and I don't think you would want to live with that kind of an answer. Should he have to wait 14 months to get a bypass?

I called and made arrangements to have it done at a local hospital then called the VA to get approval. The VA took him within 3 days. This should not be. I don't know how you can work the system, but these are the things that need to be looked into.

General Peck has already mentioned Florida's problem with the migration of people from the north. Of course, Daytona Beach being what it is, we have that problem at the VA outpatient clinic. We tried to run a test. I have had an office in the clinic the past year, and think that about 40 percent of the people that are seen in that clinic from October to May are from out of State. Whether they are visiting here or how long they stay, we don't know. But they do not live in this area. This takes away from the veterans that do live in this area. It takes away from filling the prescriptions that we need when they go out and say sorry, we've used up the quota and you can't get your prescriptions until 2 months from now.

Another problem which we haven't addressed here this morning is elderly people and insurance. A lot of our older veterans do not understand the insurance system, how to file for Medicaid, Medicare, CHAMPUS and so on. We assist them in our office, but a lot of our local doctors refuse to file for CHAMPUS, CHAMPVA, or if they do fill them out, they charge the veteran $25. Now, I understand there's a law that will be taking effect either in October or

September that requires the doctor to fill out these forms for them. I haven't seen that law, so I don't know.

The denial of fee basis cards, the older veteran that has to go to the hospital or the clinics that has the problem—for example, rheumatoid arthritis—and he has to go to the local VA facility for that condition, he arrives out there to find out that the rheumatoid doctor only comes there once a month. Well, he's having a problem now, not that 1 day a month that that doctor is going to arrive there. I think this type of individual should be provided a fee basis card. Nine times out of ten, when you apply for one, the clinic or the hospital says yeah, we have a rheumatologist and we can take care of it. It's not the case. The denial of the fee basis card I think needs to be looked into.

Medication is another problem that we have I know locally here with some of the 100 percent service-connected veterans, realizing the VA has a formulary that they go by. But in a lot of cases I have individuals that their doctor has indicated they could only take one kind of medication. It's not available in the formulary. Therefore, the individual has to spend anywhere between $100 and $150 for a prescription that he should be able to get through the VA system. The reason I mention this is because you can go across the State line to Georgia and you can get that medication without a problem.

I thank you very much, sir.

[The prepared statement of Clyde Cleveland appears at p. 66.]

Mr. EVANS. Thank you all very much.

You've had the opportunity to hear both General Peck and the VA representatives, and I think Bill had a comment he wanted to make in response. We certainly would like to get your input and reaction to what they had to say. Are there things we should be asking them which we didn't ask, which we could submit as written questions to them, regarding what they had to say and what the State and Federal partnership is like here?

Mr. CLEVELAND. I think we're talking at different levels. When you're talking down to where Bill and I work, where we're talking to the veterans, we have to explain the law, how it came about, and why they can't get the benefits. The general is interested in facilities, in nursing home beds, and he's at a different level than we are. He is concerned with what we do, but I think his area is in planning and programming and trying to provide to us what we need down here. It's our job to tell him these problems we're having so that he can program for them.

Mr. EVANS. Bill, you had mentioned the means test, and that's something that was imposed actually before Congressman James came to Congress. I voted against it. I think the resources could be better utilized actually throughout the system in providing care instead of just doing bureaucratic paper shuffling, you might say. Another provision that we need to emphasize is collecting from insurance companies for individuals who receive health care through the VA and who have private insurance. Many times we find the private insurance carriers are not reimbursing the VA as the Federal law requires. Perhaps that money could then be returned to the local medical center and we could reach more veterans. That's at least something we're considering.

I have a series of questions and I may need to have a second round. Let me start with Brian. I understand the PVA has endorsed legislation introduced by the late, great advocate for senior citizens, Claude Pepper, which would provide long-term home health care. Is there some good evidence from your organization that this kind of program of noninstitutional care would help reach more veterans?

Mr. TERWILLIGER. Our organization is doing a study right now of every member of our organization. They sent out to every member two questionnaires so they can have some variables. It covers everything that concerns the veteran—their VA health care, their personal care, and when that study is done, it's probably going to be available to you through our national legislative director, Richard Fuller, and he will be able to give you some good information on that.

Mr. EVANS. We will look forward to that evidence.

You also support an entitlement for extended care for Category A veterans. Can you estimate the cost of what would basically be a new entitlement program?

Mr. TERWILLIGER. I would have no idea as to the cost.

Mr. EVANS. Bill, on the final page of your statement you recommended more resources for the community nursing home program. In your opinion, is care in community nursing homes preferable to care in VA nursing homes?

Mr. KIRSOP. No, sir, I cannot say that. I feel—and I tip my hat to the VA employees—that if you're unfortunate enough to need a nursing home, but fortunate enough to go into a VA facility, you are well taken care of. Yes, if there was enough resources to have all the vets taken care of by the VA, I would like that, without a doubt.

Mr. EVANS. Clyde, should the State of Florida establish more State veteran home facilities and what type and how many such facilities should Florida establish in your opinion?

General PECK. Say yes, Clyde.

Mr. CLEVELAND. Yes.

[Laughter.]

Yes, we should, because the one at Lake City I was fortunate enough to visit when they finished the State nursing home, and they had enough applications to fill the nursing home before it was completed. They're talking about another nursing home, and I put a bid in for our area here, and I don't know where that one has gone now.

But I think, yes, there should be, and I would say four or five and possibly seven, because as the veteran population ages, we need these. Right now, the veterans that I have in this county, a lot of them are on VA contracts. If we had one in this county, I could fill it up probably before it was completed, just from local veterans.

Mr. EVANS. Now let me ask you the unpopular question of all of you, if I could. If the added resources needed to provide more VA nursing home care were only available by reducing other VA benefits and services or increasing taxes, what choice would the members of the panel make? I'm asking you a general question without telling you how we would raise the taxes.

Mr. CLEVELAND. Well, if that's what it takes, then you're going to have to increase taxes. I think the majority of the veterans that are in this room, if they got service that you say the taxes are going to provide, I think they would go along with the increased taxes.

Mr. EVANS. Are there any other opinions? Would you agree with Clyde on that?

Mr. KIRSOP. Sir, the cost of war is expensive, and it continues to grow. This is a part of the expense of war, whether it's World War II, Korea, or Vietnam. It took taxes to win the wars and it's going to take taxes to take care of the veteran who won those wars.

Mr. EVANS. Mr. Terwillinger.

Mr. TERWILLIGER. If you reduced the benefits, especially for non-service-connected, there would be a lot of people up in arms.

Mr. EVANS. I also think we should be looking at the insurance carriers. If we could recover some money, that's a form of taxation, you might say, that they already owe to the Federal Government.

I appreciate your being very frank in your answers. I will yield to the gentleman from Florida before I dismiss you. We appreciate your service and your frank answers.

Mr. JAMES. Thank you all so much for your testimony.

I assume none of you want to freeze COLAs on Social Security or military benefits, and I'm against that, as you know, and I'm sure Lane would say the same.

Mr. EVANS. Absolutely.

Mr. JAMES. Mr. Cleveland, you said that you got the hospitalization within 3 days. What happened in the interim? In other words, they said it would take 14 months to go to the VA hospital. What did you do, who did you contact, in order to facilitate this needed heart operation? Why the change of heart, spirit, or whatever?

Mr. CLEVELAND. Well, I had to call Bay Pines, which we still have to go through, because the medical districts under the reorganization aren't quite completed yet. I won't say who I talked to there, but I talked to an individual and said, "Let me ask you a question. If you had this problem, would you want to wait 12 to 14 months to have heart bypass surgery when they tell you you're three-quarters blocked?"

Mr. JAMES. So it was your advocacy in that instance that accomplished it. How did they justify it, paperwork-wise? I mean, they changed the classification to an emergency?

Mr. CLEVELAND. What I had to do is have him go get a doctor's statement from the clinic, and one from the heart specialist he was seeing. I mailed that to Bay Pines by express mail, and via the telephone, he said within 3 days he got a call to be in Gainesville and surgery was performed. In fact, 2 days ago he walked back in my office.

Mr. JAMES. So it had to do with the paperwork to establish that particular request for the heart bypass, to elevate it to a classification apparently that made it an emergency?

Mr. CLEVELAND. That's correct.

Mr. JAMES. Thank you very much. Thank you all. We will submit additional questions.

Is there anyone here who would like to make a statement in regard to the other testimony or any questions that have been asked, to additionally answer them? Thank you so much.

Mr. EVANS. Thank you.

Our final witnesses today are Gail Camputaro and Lynne Fagan. Gail has been Director of the Volusia County Council on Aging for the past 7 years. The Council serves veterans through their Adult Day Care and Meals on Wheels programs.

Lynne has been a nursing home administrator for the past 17 years and is currently associated with the Holiday Care Center which contracts with the VA. She is past president of the Florida Health Care Association and is also former regional vice president of the American Health Care Association.

Gail, whenever you're ready you may begin. We have your complete statement and we will include it in the record. You may proceed in any manner you wish.

STATEMENT OF GAIL F. CAMPUTARO, EXECUTIVE DIRECTOR, COUNCIL ON AGING OF VOLUSIA COUNTY

Ms. CAMPUTARO. Thank you, Mr. Chairman, and Congressman James and panelists.

The Volusia County Council on Aging is a private, nonprofit corporation which provides a variety of services to senior citizens 60 years of age and older. The majority of our funding is coming from the Older Americans Act, which is a national program, and very unique to the State of Florida is a program known as Community Care for the Elderly. Florida is the only State in the Nation with this program and they initiated it 8 years ago. The concept behind it is to provide supportive services in the home to individuals, enabling them to remain self-sufficient and self-supportive. Those services include homemaking personal care, Chore, transportation, meals, grocery shopping, et cetera.

It has been so successful in Florida that they continue in our State to fund this program. As I mentioned, it serves people 60 years of age or older. The cost per client is $1,200 a year versus $20,000 a year for institutional care.

In your letter to me, one of the concerns you had was noninstitutional care, and I hope that this committee—and I encourage you—will look into the existing programs in Florida as well as nationally, the Older Americans Act, and expand upon those to provide supportive services to avoid preinstitutionalization, without having to set up new institutes to do it.

I'm open to any questions.

[The prepared statement of Gail F. Camputaro appears at p. 73.]

Mr. EVANS. Let's go next to Miss Fagan and then we will ask you some questions.

STATEMENT OF LYNNE FAGAN, FLORIDA HEALTH CARE ASSOCIATION

Ms. FAGAN. As a representative of the Florida Health Care Association, we again appreciate the opportunity to express our concerns and give some alternatives to the community nursing home program for the VA.

As you will notice in my written testimony, the Medicaid allocation of beds in the State of Florida, or the bed need methodology, allows for a nine percent vacancy factor in the State at any given time. That means that at any point in time there could be as many as 5,000 empty beds in the State of Florida to be used by the veteran population in need of that care.

Additionally, through our bed methodology program and bed allocation, there are 11,000 new beds that have already been approved in the State of Florida which will be constructed within the next three to 5 years. Again, a significant number of those beds would be available for the veteran population.

It is our position that if the Department of Veterans Affairs would take a look at their reimbursement program and alter it to encourage participation by the private community, indeed, the Administration would not have the need to build new facilities, that the beds are available in the community, and nursing homes would be welcoming those patients.

Your current reimbursement system uses a Medicaid philosophy and, therefore, pays on a cost-related basis. Unfortunately, the Medicaid program doesn't pay true costs. Also, unlike the VA program, the Medicaid program is a segmented program. For example, drugs, physicians, therapy, dental, eye glasses, et cetera, are provided under other Medicaid programs and not required for under the Medicaid per diem paid to the nursing home.

The VA program is an all-inclusive program. When we take that patient into the nursing home, we must provide everything that that patient needs. As a result of that, nursing homes tend not to take the heavy care patient, or the patient with multitudes of medications, because there is simply not enough money to make it worthwhile.

The other disincentive is the 6 months stay. We see many, many age-related disabilities in a nursing home. Six months is not a reasonable length of time to provide rehab for that person, or in many cases rehab cannot even be expected. We find ourselves spending our emotional as well as financial resources in a way that's not beneficial, because that person will be returned to a community setting where his needs cannot be met. An Alzheimer's patient is a classic example of where you realistically cannot expect any dramatic improvement.

We would also submit that the community nursing home program is more beneficial to the veteran inasmuch as it does keep him in his home area, close to family and friends. Psychologically, that helps with his care. It's a more natural environment. VA hospitals tend to be totally, in large part, male populations, and it is also 44 percent less costly than the VA program. So with your budget concerns, we would also encourage that you take a look at those numbers.

We, as an association, as a private industry, as taxpayers, can't understand the need for the VA to duplicate these beds, particularly to duplicate them for what appears to be a temporary bulge in the elderly population. We would encourage again that the VA look at their program and make the adjustments necessary to encourage private industry to accommodate your needs.

That concludes my statement. Thank you.

[The prepared statement of Lynne Fagan appears at p. 76.]

Mr. EVANS. Thank you.

Could you give us an idea of how much you think the per diem has to rise here to realistically cover those costs and give community nursing homes the incentive to take veterans in?

Ms. FAGAN. It would be real hard to give you an overall per diem because the needs of the client are so varied. If you take someone who has simply had a stroke and needs rehab and needs minimum therapy before they can go home, obviously their overall cost to the nursing home is a lot less than someone who is severely handicapped.

In my opinion, a Medicaid type reimbursement program that allows for a fee-for-service basis would make a whole lot more sense and undoubtedly would save a tremendous amount of money.

Mr. EVANS. Miss Fagan, Don Thompson indicated that the VA needs to double its community nursing home beds census in Florida by the year 2005. Is that likely to occur, in your opinion, and if not, what would we need to do to help that occur?

Ms. FAGAN. I think it's very possible, if we can make it beneficial for the nursing home to take these clients, and also to encourage and almost insist that the VA use this program. I, for one, have been a participate in the VA program for probably 10 to 12 years, and I think over those 10 or 12 years I may have handled a maximum of 10 VA patients. So they're not really utilizing even the beds that they have under contract. Many times we've had beds available for clients, but no clients.

Mr. EVANS. Do you know how many of the over 500 community nursing homes in Florida have contracts with the VA to provide care for veterans?

Ms. FAGAN. No, sir, I don't. I don't have that statistic. I would have to provide that for you.

Mr. EVANS. Could we get that for the record, please?

Ms. FAGAN. Absolutely.

[The information appears at p. 79.]

Mr. EVANS. I would also ask, if you can get us this information, how many in Florida accept Medicaid patients.

Ms. FAGAN. Virtually all nursing homes in the State of Florida must accept Medicaid patients. It's a condition of their licensure.

We do have, of the 500 to 600 nursing homes in the State, about 50 to 75 of them that are private, all private, with no Medicaid funds. The other beds in the State that don't accept Medicaid are those beds that are connected primarily with a retirement community and are what we call shelter beds, not available to outside people.

Mr. EVANS. For your convenience, I may submit a series of follow-up questions by letter in that regard.

Ms. FAGAN. Fine.

Mr. EVANS. Mrs. Camputaro, we're all interested in the program you have, particularly adult day care, which we believe can allow families to maintain an elderly relative within the family setting with these and other kinds of services like home health care, nursing help in the home and so forth. I have been a sponsor of the Pepper bill, as I indicated earlier. Do you see this as a program that can be expanded nationwide?

Ms. CAMPUTARO. Yes, I do. I also think we need to address in relationship to adult day care the transportation needs of our aging population. It is becoming critical in our State, where we do not have a mass transportation system, and public transportation is very limited.

We do have a coordinated effort in the State of Florida under section 426, and it is working fairly well, but it is so complex with our geographic layout that I think that's another area we need to address. We work very closely with the veterans' clinic here. One of our major problems is the transportation needs of their ADC clients.

Mr. EVANS. Thank you very much.

Congressman James.

Mr. JAMES. Thank you both so much for your testimony. It's been very enlightening.

Miss Camputaro, do you have any statistics to show what percentage of the population you serve are, in fact, veterans?

Ms. CAMPUTARO. We're serving about 13,000 clients a year, and approximately ten percent of that clientele are veterans.

Mr. JAMES. Miss Fagan, I'm a veteran, let's say, and I have no assets, and I have a modest income of $4–5,000 a year, but I have available Medicare, Medicaid, because I've been in the service 10 years and was disabled. I also meet the classification for indigent need. And let's say I'm entitled to full State benefits, without the problem of having to get rid of my housing or transferring it to my children, but with no assets, and very modest income.

What would you advise me to do? Should I try to proceed through the State to get nursing home full payment, or go through the veterans' program?

Ms. FAGAN. You would be more likely to be covered for long-term care under the Medicaid program.

Mr. JAMES. Which would do what?

Ms. FAGAN. Which would pay 100 percent of your nursing home care, minus, of course, what your contribution would have to be, which is your Social Security check minus $35, or your VA benefits. You get to retain $35 for personal use, and the balance of your annuity comes to the nursing home. The State and Federal Government pick up the balance up to their limit, their cap.

Mr. JAMES. But if I could get into this new nursing home, I could get to keep my veterans' benefits or my Social Security, could I not, or both?

Ms. FAGAN. I don't think so, not to my knowledge.

Mr. JAMES. All of that you would have to turn in, too?

Ms. FAGAN. Yes. In any nursing home, your resources, your funds, go first to the nursing home, with $35 remaining with you, under the Medicaid program. Under the VA contract program, it would depend on whether or not you had a spouse living at home and so on and so forth as to how much money you could keep. But I don't think you get to keep all your benefits and get nursing home care also, if you're long-term care.

Mr. JAMES. So you would try both of them simultaneously, or advise me to?

Ms. FAGAN. I would probably contact the VA to see what we could do about getting you the supplemental income and apply for the Medicaid program at the same time.

Mr. JAMES. Please explain that 6 months rule for the benefit of the listeners.

Ms. FAGAN. When we take a VA client under contract from a VA nursing home, the maximum length of that contract is 6 months. At the end of 6 months—there may be some likelihood for a short extension. But regardless of your condition, at the end of 6 months you're going home.

Mr. JAMES. Even if you have Alzheimer's?

Ms. FAGAN. Yes.

Mr. JAMES. And you've gotten worse.

Ms. FAGAN. Yes.

Mr. JAMES. You still must go home?

Ms. FAGAN. Yes.

Mr. JAMES. You can't be recycled in place?

Ms. FAGAN. I've never had one recycled.

Mr. JAMES. Do you then have to coordinate it and make provision to go into a private home, or do you go straight from the veterans——

Ms. FAGAN. They use their social workers and we use our discharge program to try to place you in the community somewhere where you can receive appropriate care at a cost that you can afford to pay.

Mr. JAMES. So, effectively, the only thing the VA provides, in essence, is short-term nursing home care, where a high percentage of those in nursing homes, in most cases, is on a permanent basis.

Ms. FAGAN. I heard someone here testify today that there are unlimited benefits for service-connected veterans in the community nursing home programs. I have never run into that in my 12 years in the program. If that's true, I haven't seen it. All of my clients had to leave in 6 months, regardless of their condition. They may be recycled back through the hospital, or maybe there's a VA bed available for them at that time in Gainesville or Tampa, but I've never had one stay over 6 months.

Mr. JAMES. That is in a private nursing home that's funded——

Ms. FAGAN. This is a private nursing home, yes.

Mr. JAMES. You're not talking about the veterans homes?

Ms. FAGAN. No.

Mr. JAMES. Thank you very much.

Mr. EVANS. Thank you. We will dismiss you now.

We thank you all for joining us today. I see General Peck, who was our first witness, stayed the entire two hours of the hearing. We salute him for that. We salute all the veterans that have come here today and we look forward to working with Congressman James on many of these issues that you have raised.

With that, we will conclude the hearing.

[Whereupon, at 11:00 a.m., the subcommittee was adjourned.]

APPENDIX

CONNIE MACK
FLORIDA

United States Senate
WASHINGTON, DC 20510

WRITTEN TESTIMONY BY SENATOR CONNIE MACK
COMMITTEE ON VETERANS AFFAIRS
JUNE 16, 1990

Mr. Chairman, I welcome this opportunity to express my concerns regarding the future of veterans care in Florida by the Department of Veterans Affairs.

Florida's veteran population is growing way above projected levels. As of September 30, 1989, Florida's veteran population was estimated at 1.5 million, making Florida the state with the fourth largest veterans population. Yet, at the same time, Florida is in a four-way tie for 10th place in terms of medical centers nation-wide. Because of this tremendous growth and the critical need for medical center beds, my efforts for Florida's veterans to receive their fair share of federal funds are now more important than ever.

I commend the efforts of the Veterans Administration to serve the needs of veterans throughout Florida. Funds have been appropriated for the construction of a new medical center and authorized for the design of a nursing home in Palm Beach. In addition, funding has been authorized for the design of a 290 bed psychiatric center in Gainesville. As a result of meetings Senator Graham and I had with Secretary Derwinski, a permanent representative will be located in Florida as part of the Department's administrative reorganization to ensure that the needs of Florida veterans and heard loud and clear. Bi-partisan efforts such as these must continue in Florida to fulfill our commitment to providing quality health and nursing home care to America's veterans.

Recently, the Department of Veterans Affairs ruled that soft tissue sarcomas based on exposure to dioxin-containing herbicides would be treated as a service-connected disability. I wholeheartedly support this action taken by the Department.

I have co-sponsored legislation which would permit certain service-connected disabled American veterans who are retired members of the armed forces to receive disability compensation without reducing their retirement pay. I have also co-sponsored legislation to amend the Survivor Benefit Program to provide a monthly annuity for those widows whose retired husband died between October 31, 1953 and March 31, 1974. This initiative would help to correct an injustice suffered by widows of military reitrees who served 20 - 40 years, but who passed away before the Survivor Benefit Program became law.

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With this in mind, I urge the Committee on Veterans Affairs to continue its efforts to address the unique needs of our nation's veteran population. With Florida's growing and aging veteran population, we must address not only this decade's needs, but our growth into the next century. Eligibility for medical care, the allocation of VA resources, and long-term strategy and planning for hospitals, outpatient clinics, and nursing home care, are problems which must be solved well in advance.

I congratulate the Committee for attempting to solve these important issues. The Department of Veterans Affairs must adequately plan ahead for future veterans care in Florida and nationwide. Through hearings such as these, we can accomplish this goal, and fulfill the promise we made decades ago to our veterans.

STATEMENT OF THE HONORABLE CHARLES E. BENNETT, BEFORE THE VETERANS' AFFAIRS SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS JUNE 16, 1990

Mr. Chairman, thank you for the chance to testify concerning provisions related to extended care for Veterans in Florida by the Department of Veterans' Affairs.

Florida, like much of the deep south, retains a tradition of having it sons and daughters serve in the United States Armed Forces. Many Floridians who make a career in the military return to their roots at retirement. The Navy and Air Force have major installations in the state, upon retirement many people assigned to these installations stay in Florida. And, of course, many former military members retire to Florida to enjoy our tropical climate and our high quality of life.

The return of our native sons and daughters, and the influx of new arrivals, has swelled the ranks of Florida's veteran population. During the past decade, Florida has experienced a greater rate of growth in its veteran population than any other State in our Nation. With this expansion, along with a growing population base, comes the need to provide medical care and services that are mandated by law for veterans.

As a result of the growth in Florida's veterans population, there is a serious shortage of Veterans' Administration facilities throughout Florida, and Jacksonville is especially underserved. Jacksonville is the most populous city in Florida without a VA hospital and it also has one of the largest concentrations of retired and active-duty military personnel of any metropolitan area in the Nation. Three Naval Air Stations are located in Jacksonville. About 40,000 active duty military personnel are stationed in the metropolitan area. I believe it is also home to the third largest concentration of veterans in the State of Florida. Yet the nearest veterans hospital for this

major concentration of veterans is more than a three-hour round trip drive away. For many veterans lack of transportation makes this trip prohibitive so they are effectively denied benefits they are entitled to by law. Paradoxically, Gainesville and Lake City, the two nearest cities with VA hospitals, do not even have significant military or veterans presence, such as Jacksonville.

The increasing age and increasing numbers of Florida veterans will increase demand, very naturally. As the average age of the veteran population increases, and the demands on the system grow, we must locate a veterans hospital where the veterans live. The Jacksonville area, with its large concentration of veterans, desperately needs a VA hospital.

The Veterans' Administration declares that its systematic planning efforts are designed to assure that VA facilities are located where the need is greatest. Having VA hospitals an hour-and-a-half away from one of the Nation's largest concentration of veterans is unconscionable. Veterans' health care needs in northeast Florida or Duval County now require the establishment of a veterans hospital in Jacksonville.

The need for a VA hospital in Jacksonville has been apparent for many years, so for many years I have been proposing legislation to establish a VA hospital in Jacksonville. Once again this Congress I have introduced legislation, H.R. 78, to provide for a Veterans' Administration general medical and surgical hospital in Jacksonville. However, H.R. 78 is different from previous bills I have introduced to establish a VA hospital in Jacksonville. First, it no longer contains the requirement that the VA must seek to cooperate with the University of Florida Health Center in the University's activities in Jacksonville. Second, it no longer requires it be a 500-bed hospital. These two items are apparently an anathema to the Veterans Department, which told me in a letter that when it builds a new VA hospital it needs to have the flexibility to determine, on its own, matters such as these.

I am grateful for these hearings, and I hope the committee will approve the establishment of this hospital that for many years has been needed. People have said to me, "Charlie, we would like to help you out but we just don't have the money." I am fully aware that federal money is in short supply right now but I ask you to find the money for a Jacksonville Veterans hospital. But don't do it for Charlie Bennett, do it for the thousands of men and women who faithfully served our country, whom our country pledged to provide treatment for, and who call the Jacksonville area home. Do it for them.

TESTIMONY OF

THE HONORABLE EARL HUTTO

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

HOUSE COMMITTEE ON VETERANS' AFFAIRS

JUNE 16, 1990

MR. CHAIRMAN, I DEEPLY APPRECIATE THE OPPORTUNITY TO DISCUSS THE VETERANS ADMINISTRATION'S EXTENDED CARE PROGRAMS IN FLORIDA AND THE NEED TO FACILITATE THE PROPOSED CONSTRUCTION OF VETERANS HOSPITALS THROUGHOUT THE STATE OF FLORIDA. AS YOU KNOW, FLORIDA HAS OVER 1.15 MILLION VETERANS OF WHICH OVER 83,000 LIVE IN THE PANHANDLE AREA. THESE VETERANS RELY HEAVILY UPON THE MEDICAL ATTENTION THEY RECEIVE AT VA HOSPITALS AND CLINICS.

FIRST, I WISH TO COMMEND THE STAFF OF THE PENSACOLA CLINIC FOR THEIR FINE WORK AND DEDICATION IN TREATING THE PANHANDLE'S VETERANS. DESPITE FUNDING SHORTAGES AND AN INCREASED WORKLOAD, THE STAFF PERFORMANCE OF THIS FINE CLINIC HAS EXCELLED. IN FACT, I HAVE VISITED THIS CLINIC AND RECEIVED MANY LETTERS FROM VETERANS THAT CONFIRM THIS EXCELLENCE. HOWEVER, THERE ARE SOME CRITICAL HEALTH CARE PRACTICES THAT THE CLINIC IS UNABLE TO PERFORM. FOR EXAMPLE, THE CLINIC CANNOT PERFORM SURGERY AND OTHER ACUTE CARE TREATMENTS. WELL OVER 1200 VETERANS FROM MY DISTRICT WERE TREATED IN FISCAL YEAR 1989 AT FOUR AREA VETERANS HOSPITALS: BILOXI, MISSISSIPPI, MONTGOMERY, ALABAMA, AND GAINESVILLE AND LAKELAND, FLORIDA, WITH THE BILOXI HOSPITAL BEING THE MOST FREQUENTED.

THE NEED FOR A HOSPITAL IN THE PANHANDLE IS NOT EXPECTED TO DIMINISH. IF ANYTHING, THE DEMAND FOR A PANHANDLE HOSPITAL IS PROJECTED TO INCREASE. THERE ARE AT LEAST TWO REASONS FOR THIS NECESSITY. CURRENT PROJECTIONS INDICATE THAT THE VETERAN POPULATION WILL INCREASE STEADILY IN MY DISTRICT (OKALOOSA, BAY, WALTON, ESCAMBIA, AND SANTA ROSA COUNTIES) IN THE 1990s. THE NEED IS SO GREAT THAT THE NUMBER OF MILITARY RETIREES LOCATED IN THE NORTHWEST FLORIDA SERVICE AREA IS ABOUT 3 TO 4.5 TIMES

GREATER THAN THE NATIONAL AVERAGE. IN FACT, FLORIDA'S FIRST CONGRESSIONAL DISTRICT HAS THE HIGHEST NUMBER OF MILITARY RETIREES IN THE COUNTRY, APPROXIMATELY 25,000. NATURALLY, THE HIGH NUMBER OF VETERANS AND MILITARY RETIREES RELATES PROPORTIONATELY TO THE HIGHER THAN AVERAGE NUMBER OF "CATEGORY A" VETERANS IN THE AREA. AS YOU ARE AWARE, "CATEGORY A" VETERANS CANNOT BE DENIED ADMITTANCE INTO A VA HOSPITAL. THIS SUBSTANTIAL NUMBER EXPLAINS THE UNPARALLELED WORKLOAD FOR AREA HOSPITALS IN COMPARISON TO THE WORKLOAD FOR THE REMAINDER OF THE COUNTRY.

THE VA HAS ISSUED MANY REPORTS DURING THE PAST DECADE THAT STRESS THE NEED FOR A VA HOSPITAL IN NORTHWEST FLORIDA. THE VA'S 1983 MEDICAL DISTRICT INITIATED PROGRAM PLANNING (MEDIPP) SUBMISSION ESTABLISHED THE FLORIDA PANHANDLE AS A PRINCIPLE AREA IN NEED OF A HOSPITAL. THE 1989 MEDIPP REITERATED THE NEED BY STATING: "THE DISTRICT (10) CONTINUES TO SUPPORT THE ESTABLISHMENT OF A 225-BED VAMC (VETERANS ADMINISTRATION MEDICAL CENTER) IN THE FLORIDA PANHANDLE. THIS ACTION IS DOCUMENTED AND SUPPORTED IN BOTH DISTRICT 10'S FLORIDA PANHANDLE WORKBOOK AND DISTRICT 12'S FLORIDA'S 30 YEAR STUDY. THESE BEDS WILL CONTINUE TO BE PART OF MEDICAL DISTRICT 10'S LONG-RANGE PROJECTIONS UNLESS VACO (VETERANS ADMINISTRATION CENTRAL OFFICE) DISAPPROVES THE ACTION." IN ADDITION, A GENERAL ACCOUNTING OFFICE REPORT (GAO/HRD-86-148BR) ALSO CONFIRMS THIS NEED. THIS REPORT PREDICTS THAT APPROXIMATELY 100,000 VETERANS WOULD BE SERVICED BY A HOSPITAL IN OKALOOSA COUNTY. CERTAINLY, A 225 BED FACILITY IS THE VERY LEAST NORTHWEST FLORIDA SHOULD EXPECT TO RECEIVE WITH THE NUMBER OF VETERANS IN THE AREA.

ULTIMATELY, THE URGENT NEED FOR A FACILITY IN OKALOOSA COUNTY IS DUE TO THE DISTANCE VETERANS MUST TRAVEL IN ORDER TO RECEIVE PROPER CARE. MANY CITIZENS OF FLORIDA'S PANHANDLE TRAVEL WELL OVER FOUR HOURS TO RECEIVE IN-PATIENT AND EXTENDED CARE AT THE BILOXI AND THE MONTGOMERY VETERANS HOSPITALS. I BELIEVE A FOUR HOUR DRIVE IS UNREASONABLE AND COULD CAUSE UNNECESSARY COMPLICATIONS WHEN A HOSPITAL COULD BE CENTRALLY LOCATED IN THE PANHANDLE TO SERVE A GREAT NUMBER OF VETERANS.

NEXT, ACCORDING TO A VETERANS HEALTH SERVICE AND RESEARCH ADMINISTRATION WHITE PAPER, THE OKALOOSA COUNTY HOSPITAL WILL BE BUILT AFTER FACILITIES HAVE BEEN CONSTRUCTED IN PALM BEACH AND BREVARD COUNTIES. AS YOU KNOW, THE DESIGN FOR THE PALM BEACH COUNTY FACILITY HAS BEEN AUTHORIZED IN THE FY 1990 BUDGET, AND CONSTRUCTION FUNDS ARE EXPECTED TO BE INCLUDED IN THE BUDGET FOR FY 1991 AND FY 1992. COMPLETION FOR THE PALM COUNTY VA HOSPITAL IS SCHEDULED FOR MID 1994. MONEY HAS ALSO BEEN AUTHORIZED FOR THE ADVANCED PLANNING FUND (APF) FOR THE BREVARD COUNTY HOSPITAL. THE EFFORTS TO FACILITATE THESE PROJECTS SHOULD NOT BE UNDERSCORED; THEY MUST BE PLANNED AND FUNDED EXPEDITIOUSLY SO THAT CONSTRUCTION MAY BEGIN IN OKALOOSA COUNTY.

IN SUMMARY, WITH THE EXPECTED GROWTH IN THE VETERAN POPULATION IN FLORIDA AND SPECIFICALLY IN THE PANHANDLE AREA, IT IS CRITICAL THAT THE PLANNED VA HOSPITAL IN PALM BEACH COUNTY BE COMPLETED AND THE BREVARD COUNTY HOSPITAL BE STARTED AS SOON AS POSSIBLE. THESE EFFORTS ARE CRITICAL AS FLORIDA EXPANDS ITS INSTITUTIONAL AND NON-INSTITUTIONAL EXTENDED CARE PROGRAMS. FURTHERMORE, I ENCOURAGE THE CONSTRUCTION AND USE OF NURSING HOME CARE UNITS, COMMUNITY NURSING HOME PROGRAMS, AND STATE HOME DOMICILIARIES THROUGHOUT THE STATE. HOWEVER, THESE PROGRAMS DO NOT FULFILL THE NEED FOR A VETERANS HOSPITAL IN NORTHWEST FLORIDA.

MR. CHAIRMAN, I AM GRATEFUL FOR THE OPPORTUNITY TO ADDRESS THE STATE OF VETERANS HEALTH CARE IN FLORIDA.

news release

Congressman TOM LEWIS

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THE HONORABLE TOM LEWIS
FL-12

STATEMENT BEFORE THE SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS
June 16, 1990

Mr. Chairman, I greatly appreciate the opportunity to present testimony today before the subcommittee. I am heartened that the subcommittee realizes the very special needs of Florida's Veterans, and that you have chosen to convene a hearing in Florida to see and hear our concerns first hand.

As we all know, Florida has the fastest growing Veteran population of any state. There are currently over 1.2 million Veterans in Florida, and this number will grow to well over 1.5 million by the turn of the century.

Just as important as the number of Veterans, however, is the makeup of this large population. This population is aging rapidly, and this aging has two effects. First, it will put an added strain on our existing medical facilities. Second, and even more importantly, this aging will cause a dramatically increased need for extended nursing home care.

As many on this committee are aware, since coming to Congress I have been working to provide a Veteran's Medical Center and Nursing Home in Palm Beach County. While the VA has been receptive to the idea of a medical center, the nursing home has been quite another story.

Time and again the VA has either cut this nursing home out of their request, or shown an obvious lack of commitment to the project This lack of commitment has continually delayed the construction of this badly needed nursing home.

Indeed, the Palm Beach Center was originally slated to contain 625 hospital beds along with a 240 bed nursing home. However, after the VA's own study indicated that the nursing home was more important than the hospital beds, the VA opted to cut the hospital beds to 400. I supported this decision, provided that the number of nursing home beds remained the same.

The aforementioned VA study, A Thirty Year Study of the Needs of Veterans in Florida, concluded that Florida will need 2,688 VA owned and operated nursing home beds by the turn of the century. There are currently only 810 beds. This means that there are less than half the available nursing home beds per Veteran in Florida than in the rest of the country. Finally, the VA's study called for an additional 800 beds in Florida. Clearly, more nursing home beds are needed.

Mr. Chairman, we have all seen the statistics I have mentioned, and I can tell you how five thousand Veterans move to Florida every month. These are all relevant to our calculations, and they reinforce our case.

But, Mr.Chairman, as a Veteran myself, I can testify that there is much more to this story. This is a story of human lives. This is a story of people who quite literally laid their lives on the line for the defense of our country. Now, it has sadly become the story of these same people, several years later, being forgotten by the bureacracy that was designed to serve them.

As these hearings proceed, I hope this subcommittee, the entire Congress and the Department of Veterans Affairs take heed to the plight of Florida's Veterans and their need for improved extended nursing home care.

Again, I congratulate the subcommittee for taking the time and effort to come to Florida and explore our special circumstances. I can only hope that they come away with the same realization that Floridians have. This is the realization that Florida's Veterans are not being properly provided with extended nursing home care.

Testimony of
Major General Earl G. Peck
Executive Director

Department of Veterans' Affairs
State of Florida

Before the United States House
Committee on Veterans' Affairs

Subcommittee on Oversight
Investigations

June 16, 1990

Daytona Beach, Florida

Good Morning.

First, allow me to thank those responsible for this morning's hearing. Florida has much to say about VA care for elderly veterans. As will (no doubt) often be noted today, Florida has the oldest median-age population of veterans in the nation. Florida's military veterans are almost 4 years older than the national average.

My statement this morning will be relatively brief because the problem in Florida is starkly evident. While we could discourse for hours on the subject, veterans health care problems here can be summed up in a few brief paragraphs.

It seems apparent that many soldiers who, roughly 46 years ago, waded ashore at exotic places like Sicily, Normandy and Iwo Jima, developed a strong taste for life in the sun near a beach; now they live in Florida.

Interestingly, Florida's 654,000 WWII veterans constitute a larger constituency than the total number of veterans living in each of 38 other states.

Similarly, Florida has a half-dozen counties with vet

populations larger than some other, smaller states.

Florida's population of World War II Era vets - heroes of their day - are the all but forgotten ex-warriors of the 1980's and 90's. They face more difficulties in their attempts to secure VA health care than their counterparts elsewhere, although they are the most frequently and most seriously disabled veterans of any large state.

While the problems of providing health care to all veterans are both documented and pressing, those same problems have reached distressing proportions here in Florida.

The major predictive factor for utilization of veterans' health care has been, according to VA literature, accessibility. Areas privileged to have high levels of available VA health care receive high levels of services. Alternatively, veterans in localities with limited access to such care, such as Florida, are often forced to do without. In the case of long-term inpatient

care, the correlation between supply and demand is much greater.

In Florida the documented shortage of facilities, compounded by our demographics, portends a critical and worsening long-term health care problem.

The issue of providing adequate health care for Florida's veterans represents an imposing challenge. Florida has the fourth largest veteran population in the nation, a population growing more rapidly than that of any other state. Therefore, while one could reasonably predict a relative decline in health care demands elsewhere, surely those demands in Florida will continue to grow. Thus, any commission or process which would simply seek to change missions of facilities elsewhere will perpetuate the inequities with which Florida veterans suffer. There needs to be a positive change in resource allocation in the VA health care system which recognizes demographic and geriatric trends.

We have just passed the 46th

anniversary of the Normandy invasion. We need to overhaul the system to recognize that the veterans of that war who may have come from Massachusetts or Minnesota now reside in Florida in ever increasing numbers. To fail to do so will have a catastrophic effect on those whose who made the greatest sacrifices in that last "great war to end all wars" and, ultimately, on those who followed in Korea and Vietnam.

STATEMENT OF

DONALD B. THOMPSON

DIRECTOR, SOUTHEAST REGION

VETERANS HEALTH SERVICE AND RESEARCH ADMINISTRATION

DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

JUNE 16, 1990

Mr. Chairman and Members of the Subcommittee:

It is a pleasure to appear before the Subcommittee to discuss the provision of extended care services to Florida veterans by the Department of Veterans Affairs (DVA).

The Department provides health care services in five medical centers and nine satellite outpatient clinics in Florida. Each of these facilities provide a variety of extended care programs, both institutional and non-institutional. They serve a 1990 veteran population estimated to total 1.54 million, of whom approximately 523,600 (34%) are 65 years of age or older. By the year 2000, this age group is expected to represent approximately 45% (685,300) of the State veteran population, impacting our future programs significantly.

We have experienced a dramatic increase in demand for health care services for the elderly and we expect that demand to continue as the elderly population increases. The services they require range from acute inpatient care to long-term hospital and nursing home care. Utilization of our health care delivery services by the elderly veterans is known to be disproportionately greater than use by younger veterans (3 to 4 times). As the population ages, episodes of acute inpatient care rise dramatically. In time, these short-term episodes tend to be overtaken by longer term stays, and in

many cases, culminate in nursing home care. This means that the Department of Veterans Affairs must maintain the capability to provide a broad continuum of health care services. This continuum must include, in addition to acute and intensive hospital care, nursing care, outpatient care and community based health programs and social services.

In Florida, in 1990, we estimate that 34% of the veteran population is 65 years of age or older. By the year 2000, that percentage will have increased to 45%, and by the year 2020, nearly 49% of our veterans will be more than 65 years of age. The numbers of veterans 75 and older will triple during the same periods of time, increasing from 7.6% in 1990, to 21% in 2000, and to 24% in the year 2020. To meet this demand we currently operate a total of 2,656 hospital beds, 830 nursing home care beds, and 200 domiciliary beds in Florida. An additional 120 nursing home care beds are now under construction at VAMC Tampa.

Construction of a new 400-bed hospital and 120-bed nursing home care unit will begin this fall in West Palm Beach with activation scheduled in 1994. A 290-bed Psychiatric Care Facility (with 200 long-term psychiatric beds) is scheduled for construction at VAMC Gainesville beginning in 1992. Current planning calls for a new medical center and 120-bed nursing home care unit to be built in East Central Florida. An additional 120 nursing home beds are planned at the Lake City and Gainesville Medical Centers and at Orlando and Ft. Myers in conjunction with satellite outpatient clinics currently operating. These construction projects, when completed, will bring our Florida medical centers and nursing home bed totals to 3,984 and 1,680, respectively. We also have plans for a satellite outpatient clinic in Tallahassee, FL.

In Fiscal Year 1990, we expect to treat 54,562 inpatients in our five Florida medical centers and 1,838 in our nursing home care units. We will provide community nursing home

care at VA expense to an additional 1,900 veterans. We project a total of 1,204,604 outpatient visits at our medical centers and clinics in FY 1990. By the year 2005, outpatient visits are projected to increase to 1,789,100, a 49% increase over 1990 levels.

We expect to provide domiciliary care to 606 veterans at our 200-bed domiciliary at Bay Pines, FL in FY 1990. In addition, we will provide per diem assistance to residents of the new 150-bed Florida State Veterans Home Domiciliary in Lake City, which was dedicated on Saturday, May 26, 1990. This unit was constructed at a cost of approximately $5.9 million, 35% of which was supplied by the State of Florida and 65% by the Department of Veterans Affairs. We will pay a per diem of $9.33 for veterans with incomes at or below $10,824. This is the first such facility to be operated by the State of Florida.

In order to provide the most appropriate level of care, VA has developed several alternatives to long-term institutionalization in Florida. These include Hospital Based Home Care, with programs at each medical center except Lake City; Adult Day Health Care programs at Miami and Daytona Beach SOC, and Community Residential Care programs at all five medical centers. The Hospital Based Home Care program employs an interdisciplinary team of VA staff to deliver primary care to home bound patients, providing professional care, supervision, and instruction in nursing procedures and daily care. We treated 982 Hospital Based Home Care patients in 1989. Adult Day Health Care provides health maintenance and rehabilitative services to frail elderly veterans in a congregate setting during daytime hours. This program helps avoid unnecessary or premature institutionalization. We had 76 patients enrolled in these programs in 1989.

In the Community Residential Care Program, VA social workers and nurses provide limited supervision of the care veterans receive in community homes. Veterans pay the expense of room and board while the VA provides outpatient care services for the veteran. Residential care was provided to 220 veterans in Fiscal Year 1989 under the supervision of staff from each of the Florida medical centers.

In Florida, we have Geriatric Evaluation and Management (GEM) units at VAMCs Gainesville, Lake City and Miami and another is planned for Bay Pines. This is a program which provides an interdisciplinary approach to comprehensive diagnostic treatment and discharge planning for elderly patients who typically have multiple medical and psycho-social problems. In addition, a Geriatric Research, Education and Clinical Center (GRECC) is located at Gainesville, FL. The only one of its kind in Florida, the GRECC is a center of excellence designed for the advancement and integration of research, education, and clinical achievements in geriatrics and gerontology and offers consultative services to our health care providers. Its mission includes conducting various training and continuing education programs and the dissemination of research information resulting from its programs. The Gainesville GRECC is funded at $1.2 million and has a primary research focus of geropharmacology.

Questions concerning eligibility for long-term and nursing home care are frequently raised by our constituents. Under current law and regulation, nursing home care may be furnished by VA on a space and resource availability basis. When space is available, eligibility is essentially the same as for acute hospital care. We give highest priority to service-connected veterans, followed by nonservice-connected veterans requiring nursing home care after being discharged from inpatient care in a VA medical center. Unless the veteran is otherwise eligible, the nonservice-connected veteran is subjected to the Means Test. In cases in which

income exceeds criterion thresholds, the veteran has the lowest priority for care and must agree to make a co-payment if admitted to the nursing home unit.

Community Nursing Home Care is designed to provide veterans with skilled and intermediate care on a level less intense than that provided in a hospital environment. VA may transfer veterans who need nursing home care to approved private nursing homes, at VA expense, from VA medical centers, nursing homes or domiciliaries. Normally VA authorized care may not be provided in excess of six months except for veterans whose need is based on a service-connected disability. Nonservice-connected veterans must have been first hospitalized by VA, however, in order to be eligible for contract nursing home placement. Since this is not a mandatory program under the law, several of our facilities have shortened the length of contract placements in order to increase the numbers of veterans we can serve. VA nursing home placements and community nursing home placements are not intended to be of indefinite duration but rather are intended to enable our veterans to reach their rehabilitation potential and return to a level of independence in the community.

The VA methodology for determining the share of nursing home care beds which it will support is based on a 1985 survey of utilization rates conducted by the National Center for Health Statistics. VA calculates the total veterans in need of nursing home care by multiplying the age specific utilization rates times the veteran population. The VA then applies a 16% market share to the total veteran need to derive the number of veterans which it will support. Based on this methodology, in FY 1990, 11,000 veterans will require nursing home care in the State of Florida. Of the 11,000 veterans, VA will support 1,761 or 16% . In FY 1989, VA actually supported a census of 1,372 or only 78% of the estimated VA market share. As a result, in order for the VA to meet its goal of providing care to 16% of the veterans in

need of nursing home care, additional resources will be needed.

The planning goal for VA sponsored nursing home care beds is that 30% of care will be provided in VA owned nursing home care units, 40% in the community nursing home program, and 30% in the State Nursing Home Program. Since the State of Florida does not operate any state nursing home beds, the actual program mix is 66% VA nursing home units and 34% community nursing home. By the year 2005, the projected nursing census of Florida veterans will total 23,212, more than twice the 1990 estimate. To meet the 16% market share and the recommended program mix, we would need to provide a 1,114 census in VA nursing home beds (202 more than the current level), double the community nursing home census, and have a census of 1,114 in state-operated facilities.

In summary, the Department has taken considerable steps in planning to meet the increasing demand for health care of Florida's veterans through construction of new VA medical centers in West Palm Beach and East Central Florida, additional nursing home care beds throughout Florida, an additional outpatient clinic in Tallahassee, and increased funding for contract nursing home placements. From a Regional Director's perspective, I believe that Florida has continued to receive additional resources to meet the health care needs of its growing elderly veteran population.

Mr. Chairman, I am grateful to the Committee for the opportunity to comment on the status of extended care available to our Florida veterans. This concludes my prepared testimony.

PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF
BRIAN TERWILLIGER, NATIONAL DIRECTOR
CENTRAL FLORIDA CHAPTER
PARALYZED VETERANS OF AMERICA
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
OF THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
CONCERNING
THE PROVISION OF EXTENDED CARE TO FLORIDA VETERANS BY THE
DEPARTMENT OF VETERANS AFFAIRS

JUNE 16, 1990

Mr. Chairman and Members of the Subcommittee, on behalf of the members of Paralyzed Veterans of America (PVA), I wish to thank you for holding this hearing today and for inviting us to testify concerning the provision of extended health care to veterans in the State of Florida.

At the outset, PVA believes that continued under-funding is eroding the ability of the VA health care system to provide entitled needy veterans access to appropriate extended care and other medical services both in Florida and across the Nation. This problem arises primarily in the provision of outpatient, long-term, and nursing home care for veterans with "Category A" entitlement. As you know, although such medically indigent nonservice-connected veterans have clear entitlement to all inpatient treatment at VA medical centers, many of them are not entitled to outpatient care or extended care.

Because of ambiguities in health care entitlement, hospital administrators are able to ration or redirect care when resources are not available. There is no question that such restrictive health care contradicts the current emphasis on outpatient and extended care. It is certainly not in the best interest of the comprehensive health care needs of a patient or group of patients to be denied outpatient or extended care based on variable and financially motivated eligibility decisions. PVA strongly supports legislation that would provide "Category A" veterans with entitlement to the full array of VA health care services - inpatient, outpatient, and all extended care including nursing home and long-term care.

I wish to emphasize our belief that non-institutional forms of extended care must be maximized to every extent possible. These forms of care are generally less expensive than institutional care and maximize the veteran's independence. In addition, the increased development of extended care programs away from the hospital setting will compliment VA's large institutional care programs already in place.

In Florida, as in most States, any level of funding can bring extended care to more veterans if it is used for non-institutional long-term care rather than institutional care. Since insufficient funding in recent years has prevented VA from expanding extended care programs on a non-institutional basis, we believe it is essential that VA be provided with sufficient funding to meet the demands of an aging veteran population - a population which is aging much faster than the general population.

Regarding institutional settings, in our region (ie., Florida, Georgia, South Carolina, and Alabama), we believe VA is in an excellent position to further develop centers dedicated to geriatric and long-term care. Secondary care hospitals, in proximity to tertiary referral VA medical centers, represent ideal locations for long-term care through conversion of beds and mission. With the existence of such centers, veterans would have increased access to facilities which would provide a nursing home, a geriatric evaluation unit, ambulatory clinics, an adult day care center, a home care team, a respite

program, and a hospice program. We believe VA must develop this strategy of multilayered long-term care facilities in each VA medical region across the country.

We also encourage VA to expand its Home-Based Health Care (HBHC) Program in Florida. HBHCs' allow the early discharge to their own homes of chronically ill veterans who are generally expected to remain bedbound or housebound. HBHC also reduces readmissions to the hospital and has been shown to be extremely cost-effective. We believe it is critical that every VA medical center in Florida expands and improves the HBHC concept.

Extended care to an aging veteran population must also include respite and hospice capability. Respite care will enable elderly and disabled Florida veterans to be institutionalized periodically to allow a relief period for the spouse or relatives who normally care for the patient. This relief from responsibility reduces the strain upon care-givers, and they remain willing and able to provide care for the veteran (who thus avoids institutionalization) for a longer period. VA medical centers can make use of temporarily empty hospital beds and the care staff associated with such beds. The net program cost is little more than the staff time required for its coordination.

Mr. Chairman, as you know, hospice programs enhance the quality of life for terminally ill veterans. Through the use of the HBHC team, the program allows many veterans to remain at home among familiar surroundings and family. We are hopeful that Florida VA facilities will plan to maximize the use of hospice programs to include inpatient care for terminal patients during periods when they cannot be cared for at home.

Because of the large number of elderly veterans living in Florida, we are very interested in VA's Geriatric Research, Education, and Clinical Centers (GRECC's). We strongly encourage VA to integrate, to every extent possible, expanded GRECC programs in Gainesville, Florida and throughout the VA health care system. As the veteran population grows older, VA will be better able to deal with problems of the aging and develop new approaches of care for this group.

Finally, VA must continue to increase the nursing home care census in Florida, as well as nationwide. Despite our recommendation for major expansions of non-institutional extended care, an increase in institutional long-term care also remains necessary to serve the growing number of veterans who have such severe functional limitations that they cannot be cared for in a non-institutional setting. We understand that VA plans to increase nursing home capacity in Florida from 1,859 beds to 2,220 beds by the beginning of 1995 as well as the inclusion in their strategic planning of major construction projects for nursing home care in Lake City and Tampa over the next four years.

Mr. Chairman, we believe our State must lead the way in providing the latest extended care concepts for our rapidly aging veteran population. We hope to work closely with you and our various Representatives to ensure that Florida veterans, and all veterans, receive the best possible health care that we, as a Nation, can offer.

That concludes my testimony. Once again, I wish to thank you for coming to Daytona Beach today to hear our views on the issue of extended care. We sincerely appreciate your concern for the well-being of this important program.

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VETERANS OF FORFIGN WARS OF THE U.S.
VETERANS SERVICE OFFICE
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STATEMENT OF

WILLIAM R. KIRSOP
STATE SERVICE OFFICER
VETERANS OF FOREIGN WARS OF THE UNITED STATES
DEPARTMENT OF FLORIDA

BEFORE THE

UNITED STATES HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT INVESTIGATIONS

WITH RESPECT TO

DVA INSTITUTIONAL AND NON-INSTITUTIONAL EXTENDED CARE PROGRAMS IN FLORIDA, PRESENT AND PROJECTED NEEDS FOR EXTENDED CARE BY FLORIDA VETERANS, THE STRATEGY AND PLANS OF DEPARTMENT OF VETERANS AFFAIRS TO MEET FUTURE EXTENDED CARE NEEDS OF FLORIDA VETERANS, ELIGIBILITY FOR DVA EXTENDED CARE AND RESOURCES NEEDED TO PROVIDE EXTENDED CARE TO THE AGING VETERANS POPULATION. GERIATRICS RESEARCH, EDUCATIONAL CLINICAL CENTER (GRECC PROGRAM).

DAYTONA BEACH, FLORIDA JUNE 16, 1990

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for giving me the opportunity to come before you today as a member of the Veterans of Foreign Wars, Department of Florida. As the State Service Officer, my office has first hand knowledge of the problems all veterans, particularly older veterans, are having regarding medical care in Florida. Congress passed the Means Test several years ago. The intent of this law, we believe, was to ensure low income veterans received necessary health care. We have been informed by fellow service officers in many other areas of the country that their low income veterans are continuing to receive health care on an outpatient basis. That is not the case in Florida. The DVA health care facilities in Florida are taxed to the full extent by supplying health care to those veterans who have service connected disabilities as a result of military

service. Non-service connected veterans are usually told to go obtain care from the private sector because of budget and staffing problems in Florida. Many cannot afford to do so.

Continuing out-patient treatment for category A veterans that are not rated 50% or more service connected is virtually non-existent in Florida. Veterans rated less than 50% service connected make up a substantial amount of Florida's veteran population. Many of these veterans have nowhere to turn but to the DVA for their health care needs. The DVA realizes this problem. They have heard from the VFW, and other veterans organizations, about the problem. DVA is unable to rectify the problem without additional monies being budgeted and reallocation of resources from other states with a declining veterans population.

The VFW wants the service connected veteran to be treated first. We also believe that the DVA should be required to treat all war time veterans who cannot afford private medical care. There is a provision in the law which allows pre-bed care by the DVA to Category A veterans to alleviate the need for hospitalization. Medication needs for Category A veterans for their non-service connected conditions are not being supplied in the vast majority of cases. If a veteran is unable to buy needed medication, there is good possibility that he/she will need hospitalization. If medication was supplied to all Category A veterans, the need for costly hospitalization would probably be greatly reduced. Outpatient treatment is the way to go. As an example, my private insurance company pays 85% for outpatient treatment. They pay 80% for inpatient treatment. Why? They know it is a lot cheaper to keep me out of the hospital.

I would like to read a letter that the VFW has written to a number of veterans residing in Florida. (QUOTE) "Dear Mr. Veteran: Thank you for your letter received June 5, 1989, concerning treatment at Tampa DVA Hospital.

Unfortunately, the migration of numerous veterans to Florida has resulted in approximately 70% of the veterans now living in Florida, having service connected disabilities. Under DVA laws and regulations, DVA hospital care is provided on a priority basis with service connected veterans and lower income veterans having top priority. Although veterans with higher income may be provided DVA health care, this is accomplished on a space available basis and the said individuals will be charged a deductible for their care based on their level of income. However, in case of an emergency, hospital care should be provided.

The reason you were able to be treated in New Hampshire (or wherever) was that the service connected population is much lower in the northern states and space availability never posed a problem.

Although I realize you may not be fully satisfied with the answers I have given you, the law clearly defines and established eligibility for DVA care and unless you fall under Category A, your chances for outpatient treatment at any DVA medical center in Florida is almost nil." (END QUOTE) It is unfortunate that the VFW has to make excuses for the DVA from time to time. The reason we do this sometimes is because we realize it is not always the DVA's fault.

At the VFW's Ninetieth National Convention, seven resolutions were passed addressing DVA construction, staffing inadequacies in the Depar ment of Veterans Affairs Medical Centers, Category A veterans entitlement to outpatient care, and guaranteed entitlement to nursing home care. They have been presented by our National Legislative Office to the House Committee on Veterans Affairs. Not one of these problem areas has been resolved in Florida.

Veterans of Foreign Wars Field Representatives periodically visit our DVA hospitals and provide results to the DVA. Recently a report to the Chief Medical Director on Geriatrics Research, Educational Clinical Center Program, DVAMC, Gainesville stated: (QUOTE) "Three major components of the program include research, educational and clinical

activities. The research focus of this GRECC is geriopharmacology. The educational aspect is to host a DVA Physician Geriatric Fellowship Program which enables medical residents and allied health trainees to receive geriatric training. Currently two continuing education programs are available to health providers from around the state and throughout the Southeast. The clinical activities emphasis is being placed with several programs in geriatric medicine. These include the Nursing Home Care Unit, Geriatric Rehabilitation Unit, Hospital Based Home Care Program, Respite Care Program, a Geriatric Outpatient Clinic, Consultation Service and a 24-bed Geriatric Evaluation Unit. Since the VFW's last visit in FY 1986, several key staffing changes have been implemented and it appears as though the GRECC has been turned around. We wish the program continued success." (END QUOTE) We would like to see the GRECC program expanded here in Florida, and in particular, at the DVA Medical Center, Bay Pines, Florida. A substantial amount of our elderly veterans are located under Bay Pines jurisdiction.

The DVA currently has a total of 840 nursing home beds in Florida. Waiting lists for admission to our homes are not as lengthy as one may think. Why? Current DVA policy is to offer rehabilitative care and not extended care. This is so they can treat more patients. If the DVA had double the amount of nursing home beds they now have, and would offer extended care to Florida veterans, they would be full by the end of the month.

The VFW further believes that additional budgetary assistance should be provided to the DVA in the form of more capability to place veterans under contract nursing care. There is a shortage of monies available and as a result many veterans are being placed under contract for a month or two as opposed to six months as was routinely done several years ago.

Mr. Chairman, members of the Committee, again, we thank you for giving us this opportunity to come before you today. I will be happy to respond to any questions you may have.

TESTIMONY OF CLYDE CLEVELAND
BEFORE THE
SUBCOMMITTE ON OVERSIGHT AND INVESTIGATIONS

OCEAN CENTER
JUNE 16, 1990

The following are some of the concerns this Service Office has concerning the extended care to Florida's aging population:

1. The Medicaid eligibility issue, both from the standpoint of income limits (persons being disallowed because they are "over the income limit" while every penny of their income is taken to pay the nursing home charges and/or still having amounts not paid, sometimes leaving the spouse, who has no income her (or him) self, with no income or means of support from any source). Also the arbitrarily set amount which the nursing home patient is "allowed to keep as personal funds" from which (s)he is supposed to pay for personal care items, haircuts, laundry, podiatric care, etc.

2. Another problem with extended care, or the lack thereof, is that it does not cover the whole continuum of care needed. There are skilled care facilities available, at a very large cost, and Adult Congregate Living Facilities, at a lesser charge, but requ ·ing more independence of the veteran. There is no facility, except in the (Skilled Care) Nursing Home - at the higher cost to the individual, which offers intermediate care which would still meet the Department of Veterans' Affairs criteria for extended care (thereby gaining monetary assistance to the veteran). An intermediate care facility would give the extra care needed, but allow the veteran to do for himself what he can, AND COULD BE OFFERED AT AN INTERMEDIATE COST, since care would be more expensive than in an ACLF, but less than a totally skilled care facility. Medicaid assistance for ACLF's is hard to qualify for as income limits are set so low (OSS Programs, in Florida).

3. Along those same lines, many of the ACLF's, and most of the Nursing Homes (skilled care) are cost prohibitive to many who actually need that level of care. Many are on a fixed income, but are over the income limit for Medicaid, or, if not over, would have to, by law, pay so much of their income to the Nursing Home as to leave the spouse with not enough to live on. The Medicaid program is beginning to adjust the income in instances where there is a spouse at home, not enough in many instances for that spouse to live - and, of course, formerly, no adjustment was made.

4. Another area which could use development, especially in Florida is the "Out-Patient" Caregiver program. There are areas where visiting

nurses maintain such a good program, offering in-home care several times a week, and homemaker services also, that many elderly disabled are able to remain in their homes longer, AND AT LESS COST TO THE VARIOUS FORMS OF GOVERNMENT, Federal, State, and Local. Money channeled into an at-home caregiver program would be of two-fold benefit; first, maintaining the veteran/spouse in home, where they are happier and more independent, AND as a preventative measure, where many might not, with early in-home care, deteroriate to the point of needing nursing home care.

There are State and Local programs which address this, but that is generally on a County-by-County, or even City-by-City basis, and funding is not evenly available, nor is care consistent, or consistently available. Even in areas where the programs are available, many times they are based on a "Sliding Scale" basis, and those at the mid-range do not have access as the limited funds are expended on the lower range (where the need is great) and the high range income get no care because, even though they could afford to pay the program's full fee, the staff limitation is such that caregivers are totally taken up with those who meet the income requirements. Those who "can afford to pay" are expected to get the care privately, since there are private agencies which offer in-home care. The problem there is that the cost of these private services is prohibitive in any but very short-term periods for most people. Private insurance is of SOME help, but the emphasis in this instance is on SOME as not all insurance policies cover in-home care (I know of none which cover in-home home-maker services,) those which do offer the coverage, have very strict guidelines of who/what qualifies, and have set limits of (time or dollar) amount of that coverage.

5. A further problem is that in those instances where Adult Congregate Living Facility care is needed, the ACLF is not always properly run. This means, cleanliness of the facility, care to the resident, proper meals and with special diet considerations for the individual residents, proper supervision to ascertain that the residents are eating what is provided, etc. The same is true for some Nursing Homes. Many of these facilities are private, and, other than having to meet the requirements to open are not under any outside supervision. While outside supervision should not be mandatory, nor am I trying to recommend that every facility should be so supervised, in many instances, the lack of some "watch-dog" agency or

person, allows those who through lack of ability, or inertia, or "profit motive" or whatever, to give less than adequate care in less than pleasant surroundings. Another area of problem (ALSO THE OPPOSITE - AN AREA OF BLESSING TO MANY) is the extended care unit that is small enough not to even require licensing. Many of these facilities provide excellent care, and at a cost that the veteran/spouse can afford, in pleasant, home-like surroundings. The problem is those which do not.

6. In a large part of our County, and its most population concentrated area, at least, a problem of a different sort impacts on the extended care of our elderly/disabled veterans/spouses. The lack of any public transportation, not to say adequate, low cost or reasonably priced public transportation, is a tremendous problem. Many people are on the horns of a dilemma. They would be capable of living at home, with minimal assistance (such as once-a-week help with "heavy" jobs, IF they had affordable, dependable, accessible, CLOSE transportation. Bus service which would enable these persons to grocery shop, go to the doctor, etc., would be the difference between independent living or going into some sort of extended care facility for "custodial" care. Our area has a grant funded "bus service" which picks people up at home, delivers them to appointments, etc., BUT the service is not adequate for all persons to use, the cost is too high for those considered to be not eligible for free care and the area covered is so great that early response service is not always possible. I am not trying to negate the GREAT service that IS being done - only point out that there is a great gap and much more is needed.

7. This month, the new Florida Veterans Home is open. This facility will indeed meet many of the concerns which I have addressed above; HOWEVER, it is ONE FACILITY FOR THE WHOLE STATE - with bed space/living facilities for approximately 150 residents. It has transportation available to its residents, 24-hour-a-day medical service available to the residents, meals are prepared and served in a central dining facility, craft/hobby facilities are available, laundry facilities, residents are encouraged to participate in many activities at the Home and away, BUT, again, it can house only 150 veterans at a time. Further, since there is only one facility in the State, no provision has been made in the law for spouses

of veterans, so, where both partners might need extended care, that avenue of care is denied them.

The State Home has minimal limits of independence levels for its residents. They must be able to care for themselves, their immediate area (make beds, clean showers, do their own laundry in machines available, etc.) go to a central dining facility, and so on. This limitation precludes many persons who do not need the more extensive care of a nursing home but need a little more assistance than just a domiciliary.

8. In the insurance system, some provision needs to be made not only for veterans but for the entire aging population. Medicare is not alone in making the "system" of reimbursement so complicated that many who could receive help/reimbursement for care do not. Many do not know how to file the forms, or if they file, do not know how to appeal and do not have help available for this.

Perhaps this area (or Florida) is unique in this - certainly it has not been my experience in another state - that MOST doctors here refuse to file insurance, or, if they file, refuse to accept Medicare Assignment - so file in such a way that the benefit is paid to the patient and the patient must pay the doctor's bill directly (this can create problems in its own right - as that reimbursement check must be paid to doctor). At least those who file that way are providing some help to the veteran/spouse, and those persons can receive care.

For those where the doctor's office will not file at all, or will not file until the bill is paid - and then in many cases charge the patient a fee for filing - many veterans/spouses/widows (and other patients) are, in effect, denied care as many cannot afford to pay "up-front" and wait to be reimbursed. It is my understanding that beginning in October 1990, doctors are going to be <u>required</u> to file for Medicare - which will be a help. However, that does not address filing for private insurance, OR FOR SUPPLEMENTAL INSURANCE which many doctors' offices presently refuse to do.

9. AN AREA OF GREAT CONCERN IS <u>MEDICATION</u>. Medicare, private insurance, and Medicaid help with doctor's visits and hospitalization. Medicare does not take care of prescriptions, and most veterans/others have Medicare as their primary insurance at age 65. Only a few are in the favorable

position of having other insurance which keeps in effect the coverage for prescriptions once Medicare becomes effective. Many, many people, who would otherwise be "comfortable" - that is, able to get by monthly, buy groceries, etc., are living at or below the poverty level because of average monthly amount paid for on-going prescriptions for one or more family members. It is not unusual, in my experience, to see veterans who spend between $100 and $150 or $200 per month just for medications for him or herself and spouse.

Costs of medications are spiraling, as are all other living expenses. In addition to that, the cost of research and development of new medications greatly increases the cost. Generic brands are helping, but not in the new medications area which are protected by copyright for 17 years. It would be easy to say "don't use the new medications," but since they are more effective, or have less side effects or are for diseases for which no medication has before been developed, one cannot. Something needs to be done to address this area of extended - and other - care.

10. Finally, extended care and other care for the aging veteran population cannot be covered without reference to CHAMP-US and CHAMP-VA. CHAMP-US DOES have Nursing Home coverage in the policy if certain requirements are met. CHAMP-VA, on the other hand DOES NOT COVER Nursing Homes. There are other inequities in the programs too numerous to go into now, however, the major point is that CHAMP-US and CHAMP-VA do not cover a veteran/spouse, etc., after that person becomes eligible for Medicare AND MEDICARE COVERAGE IS NOT AS COMPREHENSIVE AS CHAMP-US or CHAMP-VA, even with the shortcomings of each of those two programs. Veterans/spouses need to have that coverage which was promised to them, which the veteran earned by his service and sometimes by his life or health, ALL OF THEIR LIVES, not just until Medicare becomes effective.

If Medicare must be considered to be the primary provider, some program should be established whereby, CHAMP-US or CHAMP-VA could become the supplemental provider at that time, covering the balance of cost above Medicare up to the amount which CHAMP-US or CHAMP-VA would ordinarily provide, TO INCLUDE PRESCRIPTIONS, long-term nursing home care, and others. Another alternative would be for those eligible for CHAMP-US or CHAMP-VA coverage to be allowed to continue under that program their

whole lifetime and not to be forced to lose the coverage when Medicare eligibility begins (even if the person elects not to take Medicare, the CHAMP-US or CHAMP-VA benefit is lost).

THE ABOVE ARE PROBLEMS WE ALREADY FACE DAILY IN OUR DISTRICT and in the State of Florida. The problems will only grow worse as time passes because, first, our present population is aging AND, secondly, we are a "growth" State. Florida is the fastest growing State in the Country in terms of Veteran Population, from shifting population trends which began around World War II. Florida has the largest percent of veterans over the age of 65 of any State in the Country. Not only is the aging veteran population growing - so is the aging non-veteran population - and they have the same needs and concerns.

The Geriatric Research and Treatment field is growing, but not fast enough to keep up with the aging population. The Florida Department of Veterans' Affairs has established a Geriatric Department at VAMC-Gainesville. The Department at Gainesville Medical Center does research, education, and provides clinical service. The education is for the professionals offering the care, but is also for the families (Care-givers) and for the patients. There is a Geriatric Evaluation (In-Patient) Unit at the Department of Veterans' Affairs Medical Center in Miami and a Gero-psychiatric (In-Patient) Care Unit at The Tampa Medical Center. The Out-Patient Clinic here in Daytona Beach has an Adult Day Health Care Unit, the only such program located in a satellite out-patient clinic in the Country. The private sector also has Adult Day Care Programs, support groups, and so on. And, as mentioned earlier, there is some Home Health Care for the Elderly available. However, in the field of Geriatrics in the future, a whole-system-care program must be a priority. Things like the transportation availability and in-home care of either home-making or nursing or supervision or any combination thereof, and facilities which offer MORE than retirement living, but not as much as nursing homes, as discussed above, must be a part of the whole "treatment." Allowing an aging veteran population as much independence as is possible while providing the maximum amount of care and support assures these people a comfortable, secure, dignified life in their declining years.

This is especially important in Florida, because here more than any other place (and the problem is very prevelant everywhere in the mobile society that is America today), our aging veteran population so often DOES NOT have the normal family support system available to them. Many of them have no family at all except a spouse, and often, not even that. With many of those who are couples, one is disabled beyond the limits of care the other can give in the home. Those who do have family, children, grandchildren, or others who would, under normal circumstances provide much of the in-home "supplementary care" (i.e., helping with heavy house cleaning, taking veteran/spouse shopping or to the doctor, helping fill out Medicare Insurance forms, dealing with other day-to-day business, helping with baths, or special diet preparations, giving or supervising the taking of medications, etc.) are thousands of miles from the nearest family, and, in many instances from friends, social groups which provide alternate sources of support/care.

This presentation is not trying to say that nothing is being done in any of the areas addressed, only that the above are all great areas of concern and there is much that needs to be done still. Many different agencies, both governmental and private are addressing various parts of these concerns. Much more needs to be done.

COUNCIL ON AGING OF VOLUSIA COUNTY
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Submitted by:
Gail F. Camputaro
Executive Director

Department of Veterans Affairs
Testimony For The Subcommittee On Oversight And Investigation
Daytona Beach, Florida
June 16, 1990

The Council on Aging of Volusia County, a nonprofit corporation, provides a variety of services which enable senior citizens to remain self sufficient and independent in the later years of their lives. Services are made possible through the Older Americans Act (federal), Community Care for the Elderly (state) and Transportation for the Disadvantaged & Handicapped (state and federal) grants.

The Older Americans Act (OAA) is a nationwide program which enables us to provide Meals on Wheels to homebound seniors 60 years and older who are without a support system. A hot noon meal is delivered to the client five (5) days a week by a volunteer. In addition to home delivered meals the OAA grant enables us to offer congregate dining for seniors 60 years and older. A hot noon meal is provided at ten (10) facilities around the county for seniors who are ambulatory, transportation is provided for those who do not drive. Socialization and activities (recreational and educational) are also part of this program. Other services provided by OAA funds are senior employment referral, telephone reassurance, companionship, and counseling. This federal grant also enables us to offer a Guardianship Diversion Program which helps a client through financial counseling and management services and reduces the possibility of a person being exploited.

OAA does not have any income eligibility criteria but contributions are encouraged and local matching funds are required.

Community Care for the Elderly (CCE) is a program started in the State of Florida in 1982 designed to prevent pre-institutionalization of elderly. The following services are available to seniors 60 years of age and older: Case Management, Information & Referral, Personal Care, Homemaking, Chore (house repairs), Meals, Transportation, Adult Day Care, Respite Services and Lifeline. In addition to this program Florida now has central area telephone numbers for a "Better Living for Seniors" network of information statewide for the elderly.

CCE has an income eligibility criteria with a sliding fee scale and local matching funds are required.

Transportation is available to any disadvantaged or handicapped person in our county. It is funded through the State Department of Transportation, Section 18 and Section 16B2. Clients are either sponsored by an agency who pay for their trips or they can ride and pay the required fare. The majority of transportation is medically related.

Recommendations

Florida has established a delivery system of services for senior citizens which is available to veterans.

On a national level this could be made possible through the expansion of services of the Older Americans Act (OAA). Specifically home services should be added to enable elderly the benefits of remaining in their homes. (Personal Care, Homemaking, Chore and Respite.) The Better Living for Seniors telephone network could also be established in each state through OAA.

Transportation is one of the greatest needs amongst elderly, especially veterans. The cost is to often prohibitive and many people are unable to use the existing system to access needed service because of this factor. Funding to subsidize this service could also be made possible through the Older Americans Act.

Our agency feels strongly that any services offered to the elderly should require a fee based on ability to pay.

Older Americans Act (Title III (B) C1, C2)
Community Care for the Elderly (State of Florida)
Transportation (Department of Transportation (Section 18,
Section 16B2)

TESTIMONY OF FLORIDA HEALTH CARE ASSOCIATION - LYNNE FAGAN

TO THE

HOUSE VETERANS SUBCOMMITTEE

ON

OVERSIGHT AND INVESTIGATIONS

JUNE 16, 1990
SATURDAY

Mr. Chairman and Members of the Committee:

Florida Health Care Association and its Members appreciate the opportunity to present our perspective on the challanges facing the Veterans Administration in providing for the ever growing number of aging veterans in Florida requiring long terms health care. Clearly the challanges are many and the dollars few.

First, let me tell you about Florida Health Care. Florida Health Care Association is a trade association reepresenting over 500 nursing homes in the state of Florida or about 90% of the nursing home beds in the state. Florida Health Care Association represents both for-profit and not-for-profit facilities. Additionally, Florida Health Care Association represents Adult Congregate Living Facilities in the state; these are facilities providing custodial care in a largely residential type setting.

The members of Florida Health Care Association have great concern about the direction of VA's Community Nursing Home Program. The State of Florida has a very strict bed need policy with emphasis on Medicaid availability. Florida has one of the lowest bed ratios per thousand in the nation and yet the industry has been successful in accommodating those in need of care without long waiting lists or the need to move the person out of their community. The entrance of the VA into this equation could upset the delicate balance that has been established for the industry.

The Florida bed need methodology does allow a 9% vacancy factor. This means that today, there could be approximately 5,400 vacant beds in the state that could be utilized for veterans and yet, the VA's Community Nursing Home Program accounts for only a small percentage of our patients; and this in spite of the fact that a recent study of the annual cost of nursing home care in the CNH program shows a 44 percent savings to the VA can be achieved in this program. Also, under our bed need formula, there have been an additional 11,000 bed approved for construction as of this date. So as you can see, there are ample available beds in Florida today and will be in the future to accommodate the growth in the veteran nursing home population. One other consideration should be that the population bulge now forcasted for the World War II veteran is largely a temporary need and once accommodated, the Administration will not have the occupancy to justify the ongoing expense of operating the bricks and mortar. On the other

hand, an expansion and adjustment of the CNH program could benefit both the veteran and the non veteran population.

EXPANSION OF COMMUNITY NURSING HOME PROGRAM:

The current benefits available under the CNH program for nonservice-connected health needs authorize up to six months in a community nursing home provided the funds are available. As the VA finds itself increasingly dealing with the elderly veteran as opposed to the disabled veteran, the need for true geriatric long term care will be evident. The community based nursing home is the place to provide this care. It allows the veteran to remain close to home, near family and friends. The Community Nursing Home has the expertise to care for the geriatric patient as that has been our vocation for many years. Our facilities have all of the amenities and additionally, more closely represent a natural environment rather than the totally masculine population commonly found in the VA facility. Then, as the veteran population in need of nursing home services decreases, the facilities will be available in the community to handle the post-war baby-boom population that is the next bulge that will have to be accommodated by the nursing home industry.

ADJUSTMENTS TO THE COMMUNITY NURSING HOME PROGRAM

From the industry perspective, the all inclusive Medicaid based rate authorized by the CNH Program is a disincentive to participate. With a VA patient, the initial period of care is the most expensive. As patients are stabilized and rehabilitated, cost of care gradually decreases. Many times, the veteran is admitted to the nursing home with a plethora of medications and therapies. All of this must be paid our of the allowable per diem. It is seldom adequate; thus the losses. As the patient improves and the medications and therapies are reduced, the allowable rate begins to cover our cost of care and only then does the facility begin to recover its initial loss. The Medicaid reimbursement methodology is totally inappropriate as a basis for VA services. It tends to rely on some subsidy by the private paying patient and tends to be cost minus rather than fee for service. A more equitable reimbursement system is that used by the Medicare program; a cost related, prospective payment system to cover routine costs with special services paid on a fee for service basis. The bottom line is that in order for the VA to attract participation by the community nursing home and to encourage the industry to respond to the projected needs of the Veteran, the

Federal Government must be willing to support rates that allow private industry to construct and operate quality nursing facilities. We believe that every resident is entitled to the best quality of care affordable and widest range of choices as to where that care is rendered. We know that nursing homes in Florida can and do respond to the need and do it better and cheaper than government.

Again, we appreciate the opportunity to speak to you today. This concludes our testimony. We will answer any questions you may have.

Holiday
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October 2, 1990

Mr. Mike Durishin
Committee on Veterans Affairs
335 Cannon
House Office Bldg.
Washington, D.C. 20515

Dear Mr. Durishin:

In response to your request, I have researched our records for the number of facilities that participate in the VA Contract Nursing Home Program.

The State of Florida has approximately 600 licensed nursing homes, of which approximately 225 participate in the program.

I hope this information will be of use to you.

Sincerely,

Lynne L. Fagan
Administrator